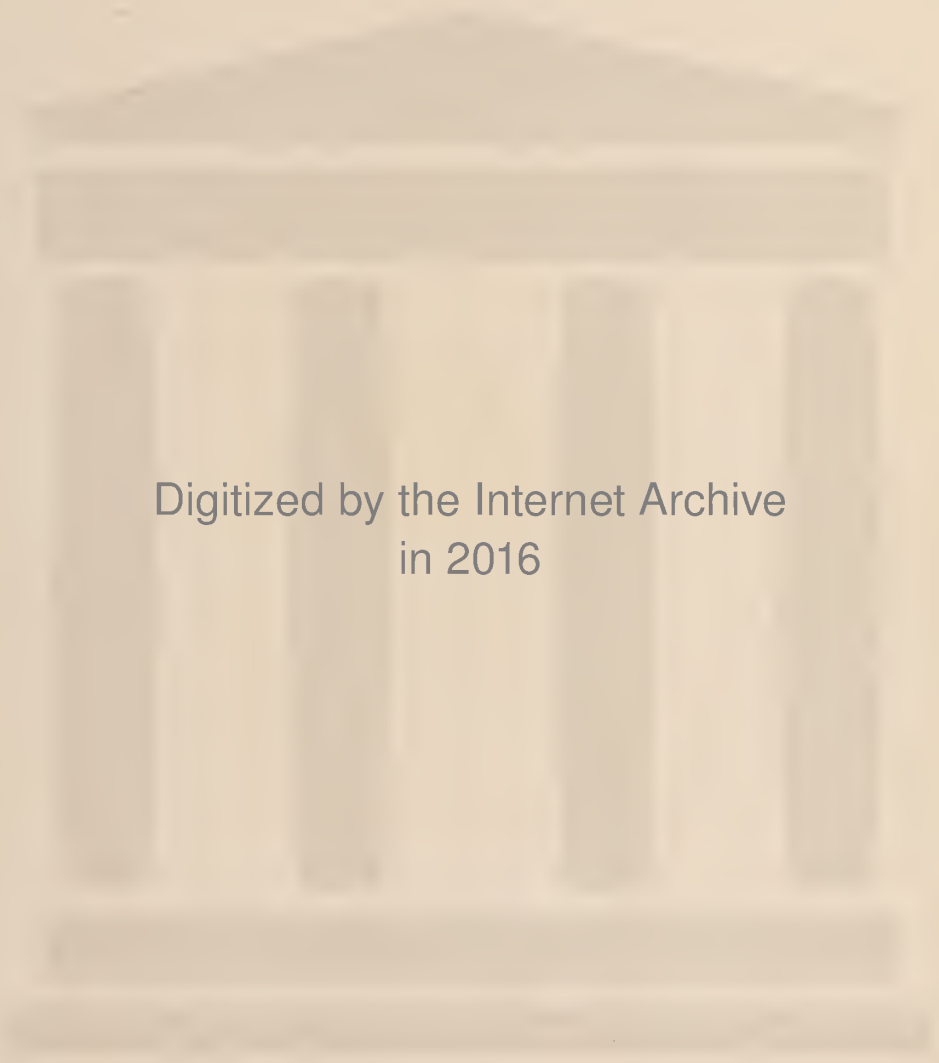
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THE JOURNAL

OF

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CONTENTS—Pages 1 to 40

N.Y. ACADEMY OF MEDICINE JAN 20 1959 LIBRARY

EDITORIALS— Page

Medicine's Shield of Security 1

Throw Physic to the Dogs 2

ORIGINAL ARTICLES—

The Patient's Team—Kenneth E. Gardner, M.D., Bloomfield, N. J. 3

The Expanding Frontier of Cytology—Howard B. Miller, M.D., Fairlawn, N. J. 9

Coagulation Defects and Pregnancy—Robert C. McElroy, M.D., Philadelphia, Pa. 14

Massive Intraperitoneal Hemorrhage Due to Paracentesis—Nurollah Hakim, M.D., Walter Hasbrouck, M.D. and Robert K. Spiro, M.D., Montclair, N. J. 19

Cancer of the Large Bowel—Samuel A. Goldberg, M.D., Newark, N. J. 22

ORIGINAL ARTICLES— Page

Blood Levels and Urinary Excretion of a Long-Acting Sulfonamide—Otto Brandman, M.D., et al., Maplewood, N. J. 24

Fluoroscopic Sign of Pulmonic Stenosis—Henry Green, M.D., Newark, N. J. 27

GOLDEN MERIT AWARD CEREMONY 30

OBITUARIES 31

ANNOUNCEMENTS 32

MARGINALIA OF MEDICINE 33

COUNTY SOCIETY REPORTS 34

BOOK REVIEWS 37

NTA ABSTRACTS 39

Roster of Officers and Committee Chairmen, Advertising Page 3A

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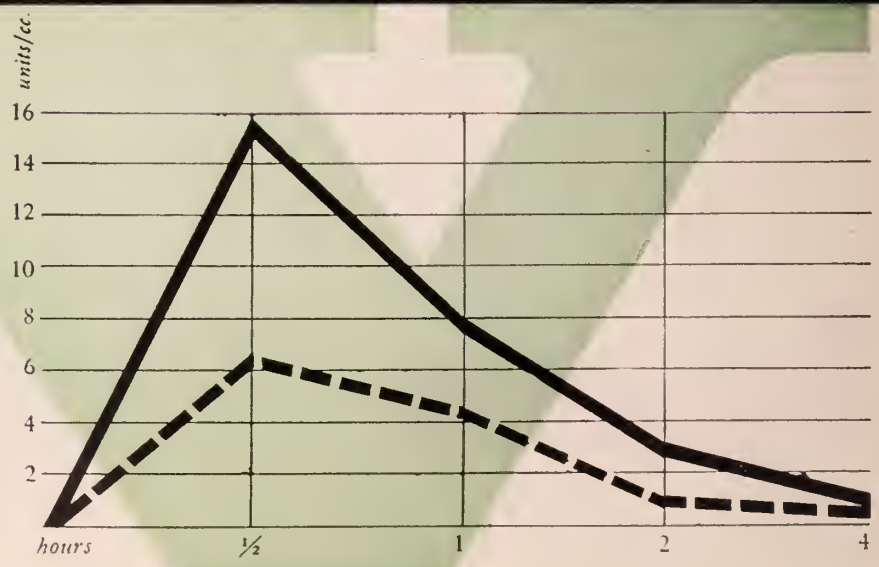
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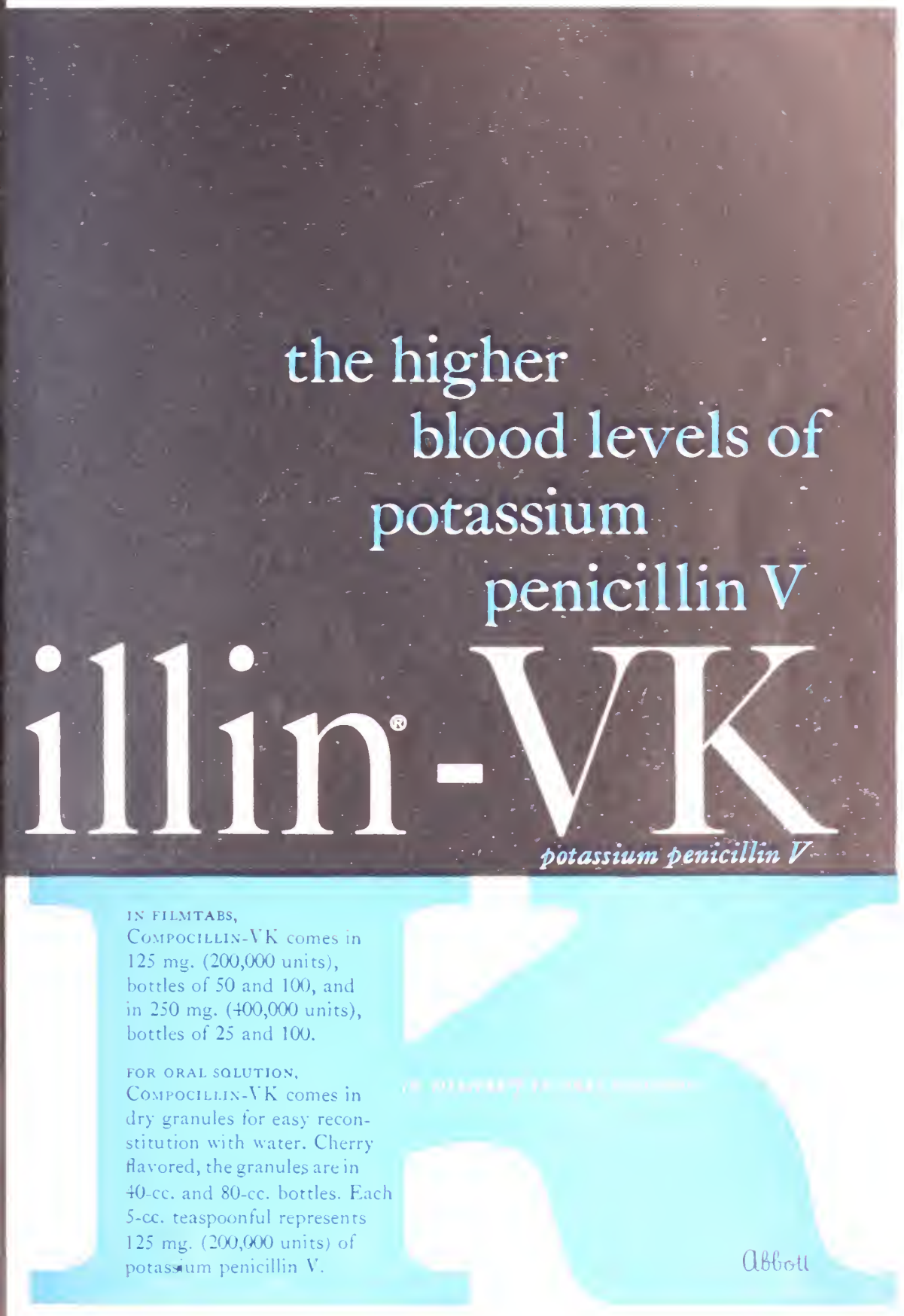


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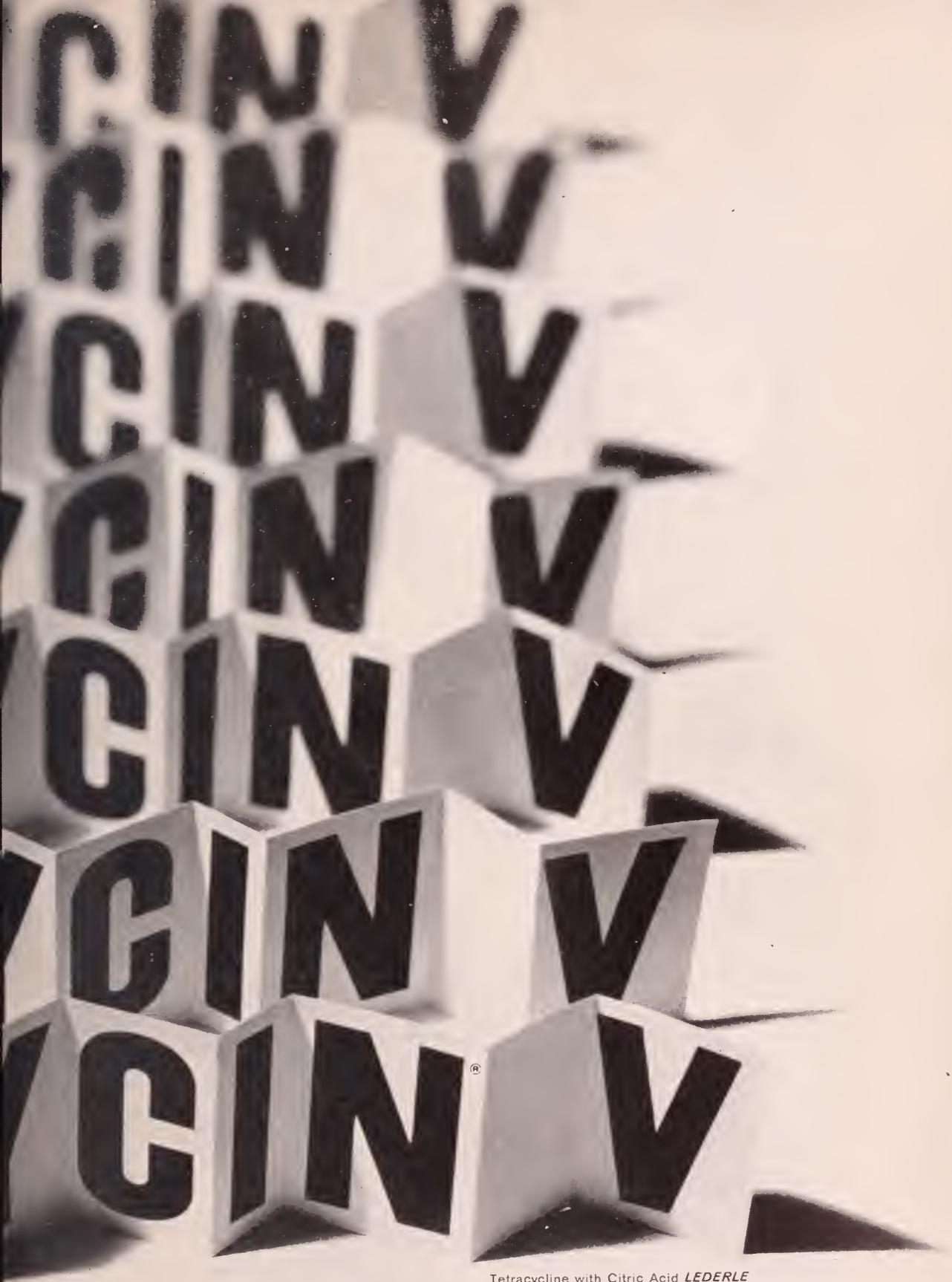
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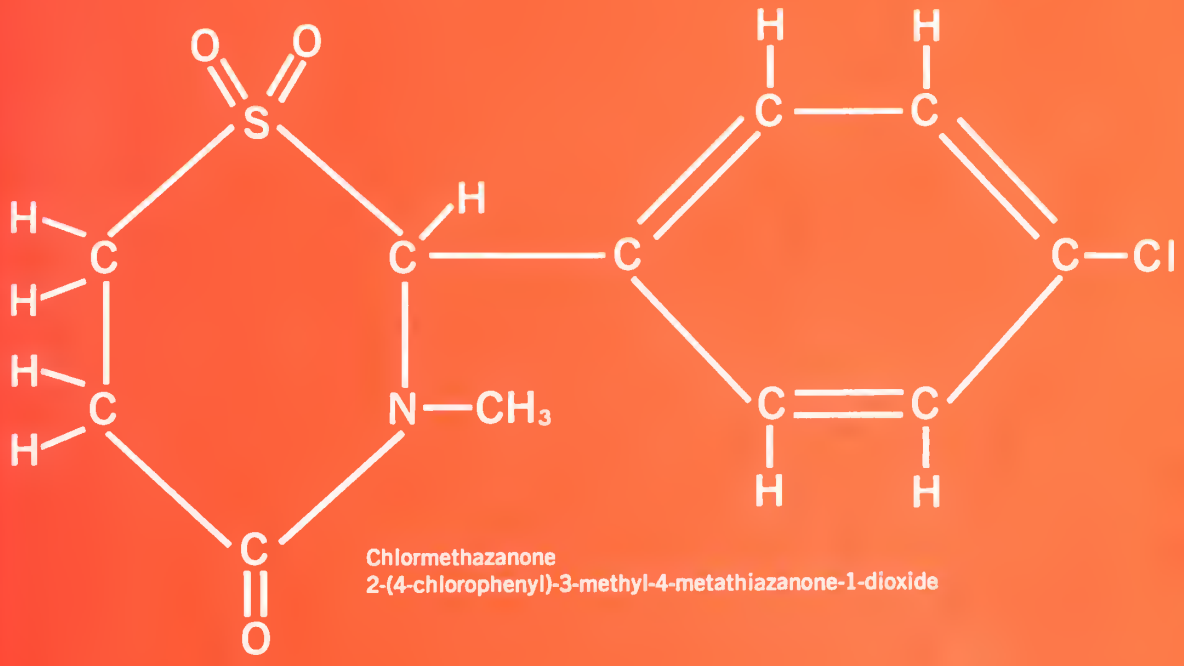
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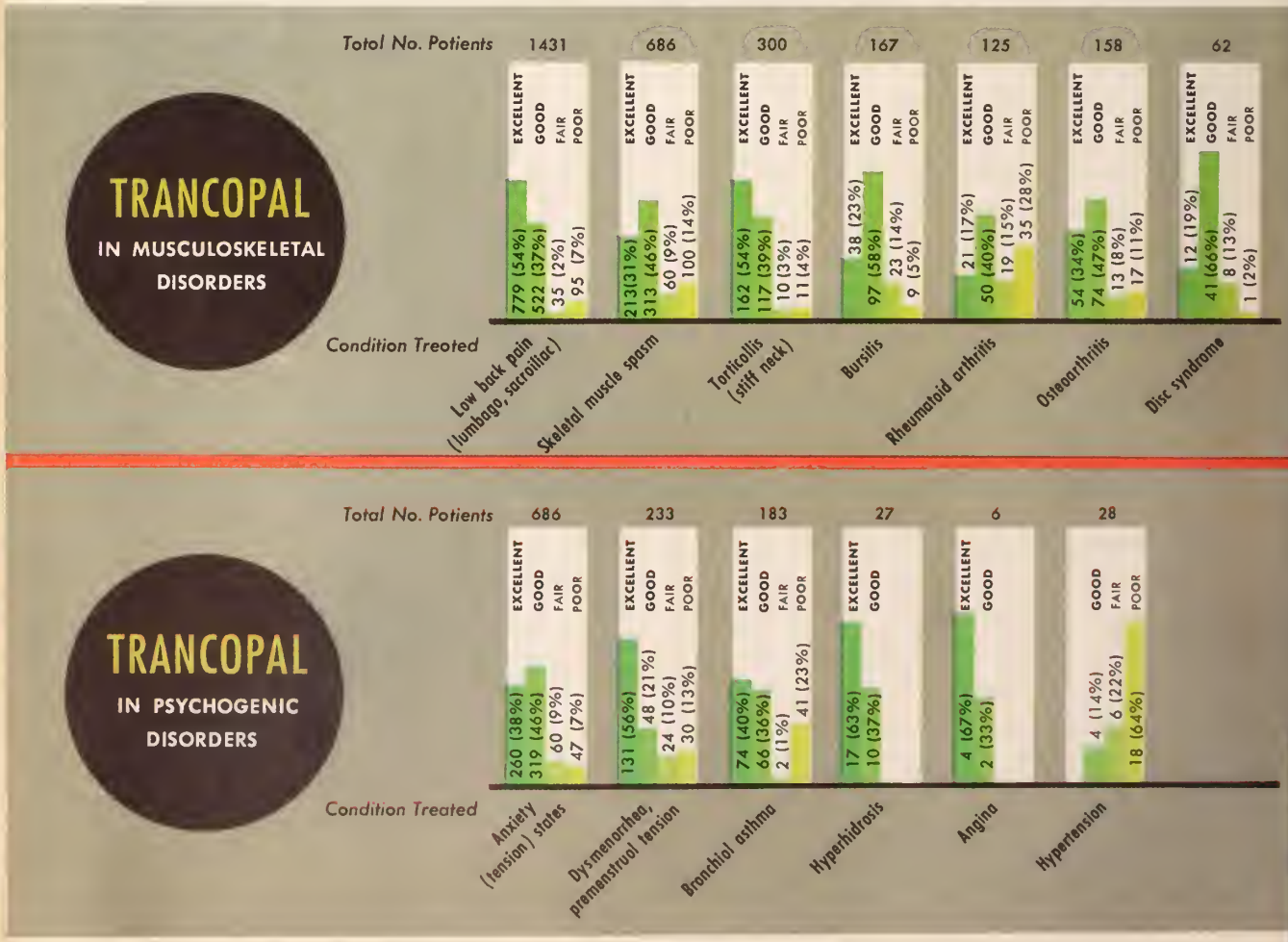
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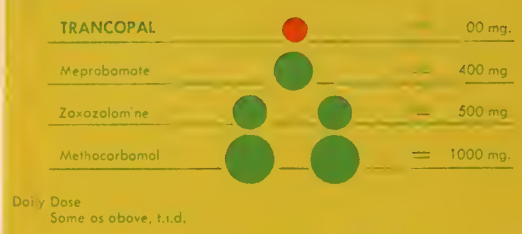
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MAJOR IMPROVEMENT
84%

**Cooperotive Study, Department of Medical Reseorch, Winthrop Laborotories

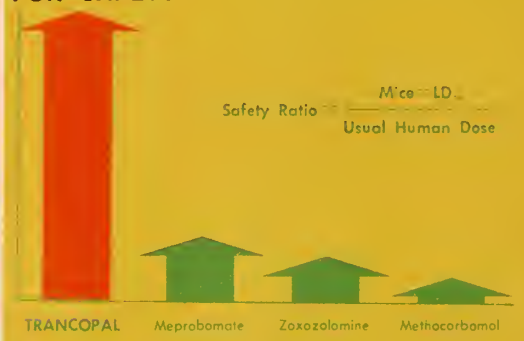
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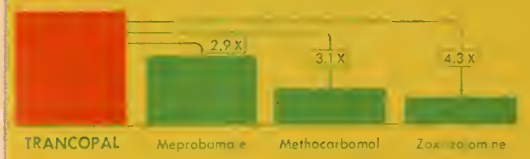
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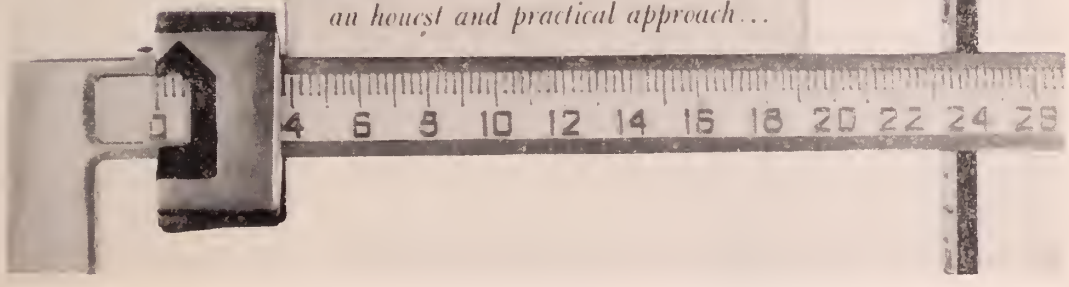
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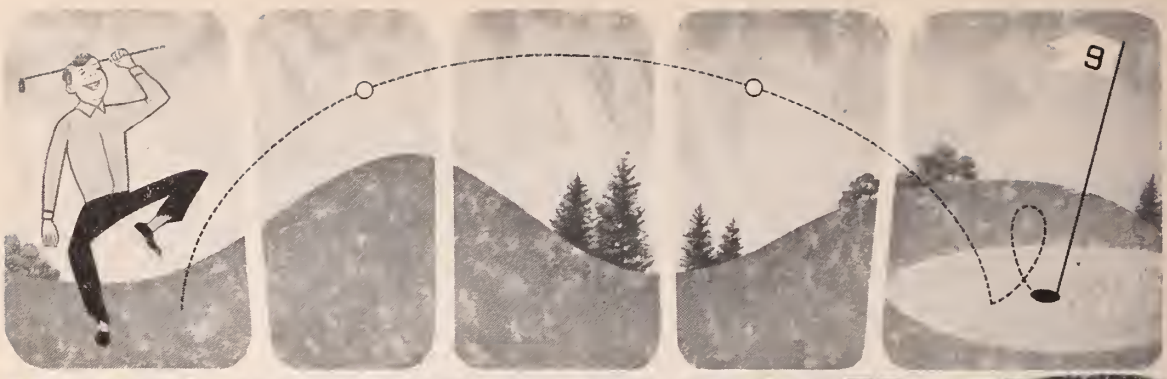
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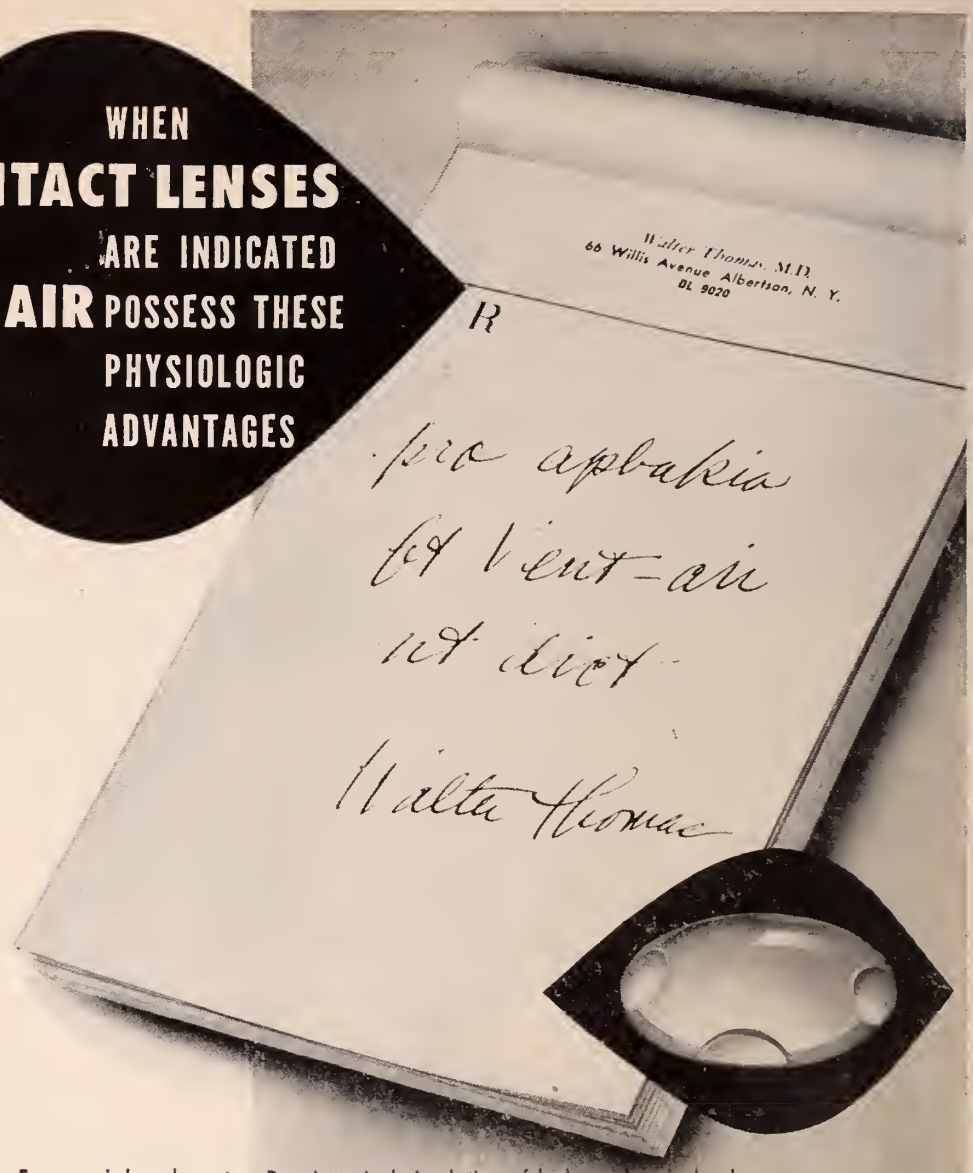
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Ultra-Smoothness of Inner and Outer Surfaces	Avoid limbal epithelial and torsal conjunctival exacerbation
Highly absorptive methyl-methacrylate composition	Simulates "wetting" and moisture-retention properties of cornea (of military specification)
Precision-ground	Prescriptive qualities exact to ± 0.12 D. with precise allowance for vertex refraction and lachrymal factor (exact to .02 mm radius in inner curvature)
Custom-fitted	In uni-, bi-, or tri-curve radii conforming to corneal peripheral asphericities
Hyper-thinness of edge or center	Maintains uniform thickness in high myopia or hyperopia approximating .20 mm irrespective of power
Widest range of inner radii	From 5.0 to 10.00 mm providing for extremes of keratoconic and megaloglobic dimensions
Cosmetic, pin-hole and tinted effects	For leucomatous, polyopic, iridodialytic and albinic conditions or other corneal or media anomalies.

VENT-AIR CONTACT LENS LABORATORIES • NEW YORK, N. Y.

for depression

Deprol†

Clinically confirmed in over 2,500 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation

► restores natural sleep

► reduces depressive rumination and crying

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function

► causes no excessive elation

► produces no liver toxicity

► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†TRADE MARK
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Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N. J.*

In potentially-serious infections...

*TRADEMARK, REG. U. S. PAT. OFF.

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**TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

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The Upjohn Company, Kalamazoo, Michigan

Upjohn

Make new

Panalba*

(ANmycin† Phosphate plus ALBAmycin**)

Your broad-spectrum antibiotic of first resort

Effective against more than 30 common pathogens, even including resistant staphylococci.



Available forms:

Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

Tetracycline phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride 250 mg.
Novobiocin (as novobiocin sodium) 125 mg.

Panalba KM †† Flavored Granules, 60 cc bottle. When sufficient water is added to the bottle, each teaspoonful (5 cc.) contains:

Tetracycline (tetracycline) equivalent to tetracycline hydrochloride 125 mg.
Novobiocin (as novobiocin calcium) 62.5 mg.
Potassium metaphosphate 100 mg.

Dosage:

Panalba Capsules. Usual adult dosage is 1 or 2 capsules 3 or 4 times a day.

Panalba KM Granules

For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 30 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the in-

BONADOXIN®

(tablets and drops)

STOPS STOPS STOPS MORNING SICKNESS



BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic...stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride . . 8.33 mg.
Pyridoxine hydrochloride . . . 16.67 mg.

Dosage:

under 6 months	0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years	1.5 to 2 cc.	
2 to 6 years . .	3 cc.	
adults and children over 6	1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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Science for the World's Well-Being

in peptic ulcer

REFRACTORY CASES RESPOND TO

NEW DARICON*tablets

OXYPHENCYCLIMINE HYDROCHLORIDE

POTENT ANTICHOLINERGIC ACTION

curbs secretion when excessive
normalizes motility when overactive

Activity appears to be restricted to the desired site of action.
Predictable therapeutic response in refractory cases.

Potency and Prolonged Duration of Action
10 mg. b.i.d. Average Dose · Supplied as:
10 mg. white, scored tablets

References: 1. Finkelstein, Murray: Journal of Pharmacology and Experimental Therapeutics, in press. 2. Winkelstein, Asher: Paper in preparation.

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in cases of tension

Serpate®

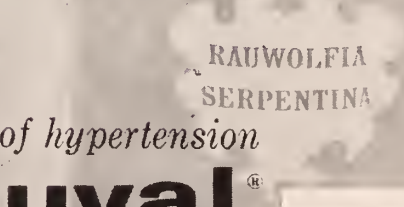
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. . . the preferred drug where anxiety or emotional agitation must be controlled

. . . provides sedation without hypnasis, a sense of relaxed well being and tranquility

. . . effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies



in cases of hypertension

Rauval®

(Rauwolfia Serpentina, Vale)

. . . double assayed to insure optimal therapeutic effect

tested chemically to insure total alkaloid content

tested biologically to insure uniform hypotensive action

. . . ideal therapy in labile and moderate hypertension or as adjunctive therapy in severe hypertension

. . . achieves gradual lowering of the blood pressure, gentle sedation, tranquilization with prolonged effect even after cessation of therapy

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PHARMACEUTICALS

A workhorse "mycin" for common infections



respiratory infections

prompt, high blood levels

consistently reliable and reproducible blood levels

minimal adverse reactions

With well-tolerated CYCLAMYCIN, you will find it possible to control many common infections rapidly and to do so with remarkable freedom from untoward reactions. CYCLAMYCIN is indicated in numerous bacterial invasions of the respiratory system—lobar pneumonia, bronchopneumonia, tracheitis, bronchitis, and other acute infections. It has been proved effective against a wide range of organisms, such as pneumococci, H. influenzae, streptococci, and many strains of staphylococci, including some resistant to other "mycins." Supplied as Capsules, 125 and 250 mg., vials of 36; Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.

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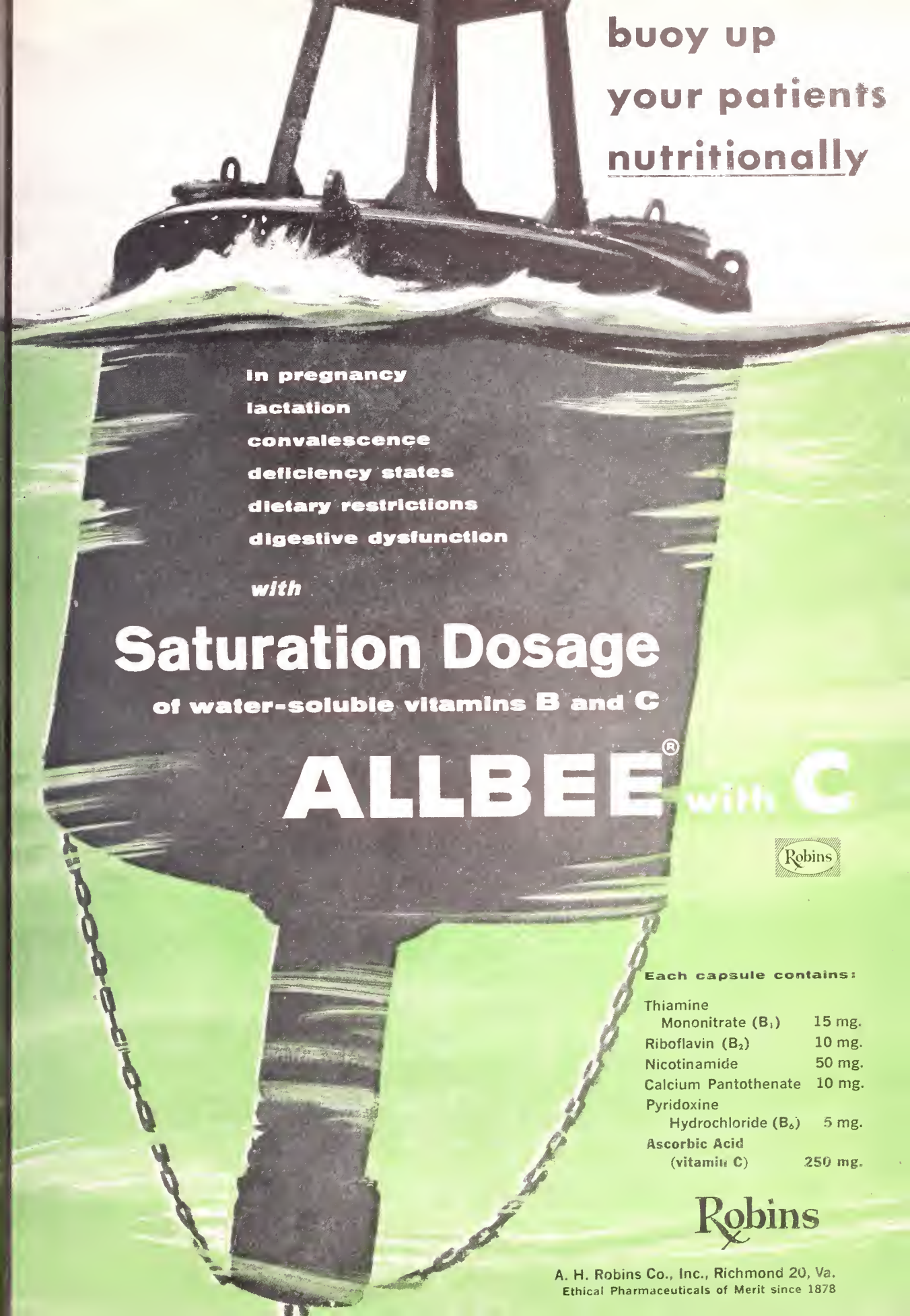
Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
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nutritionally
in pregnancy
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Each capsule contains:
Thiamine Mononitrate (B_1) 15 mg.
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Nicotinamide 50 mg.
Calcium Pantothenate 10 mg.
Pyridoxine Hydrochloride (B_6) 5 mg.
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Ethical Pharmaceuticals of Merit since 1878



"ankle-itis"

there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis — or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-dosage corticosteroid therapy—

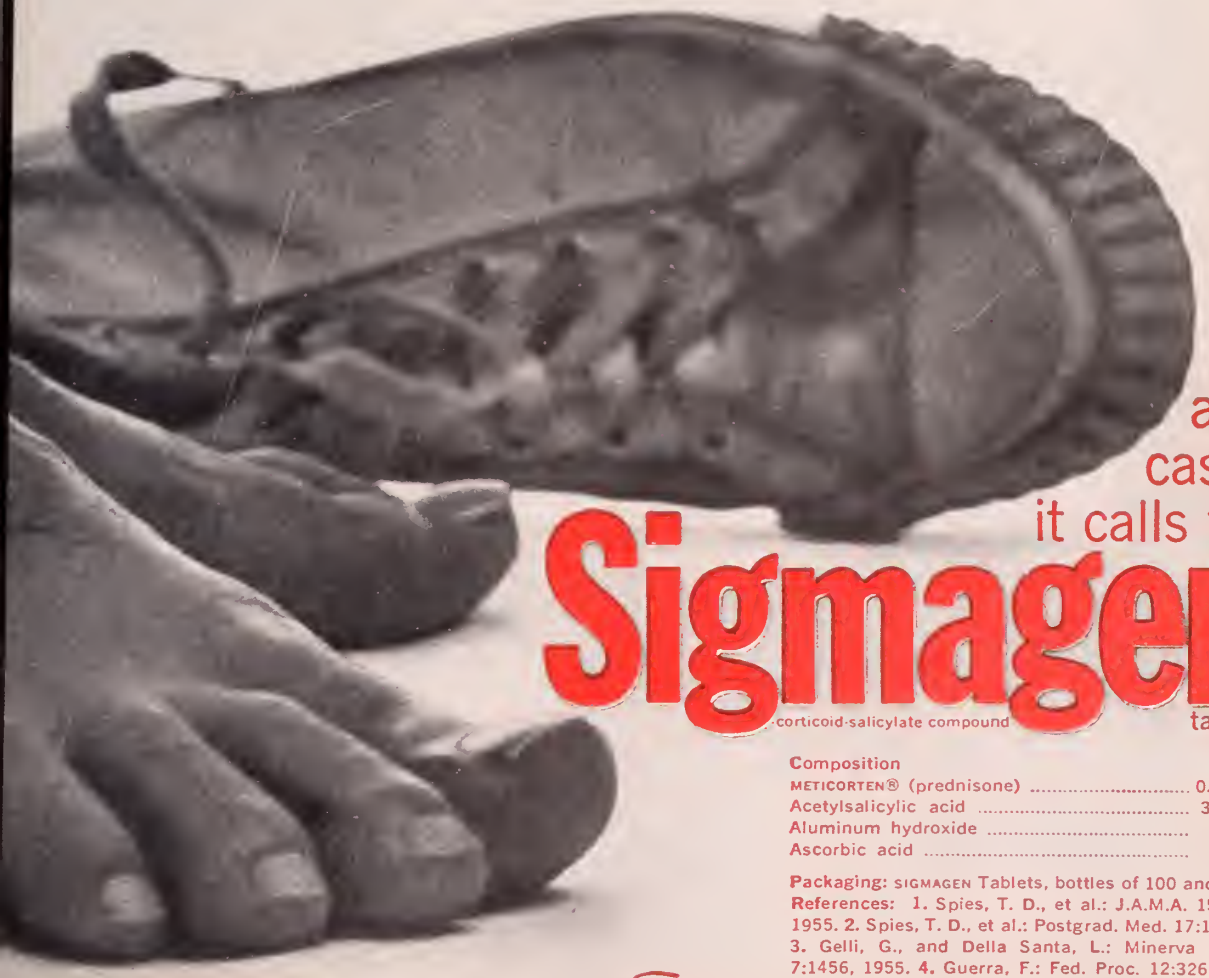
much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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What differentiates "renal diabetes" (renal glycosuria) from diabetes mellitus?

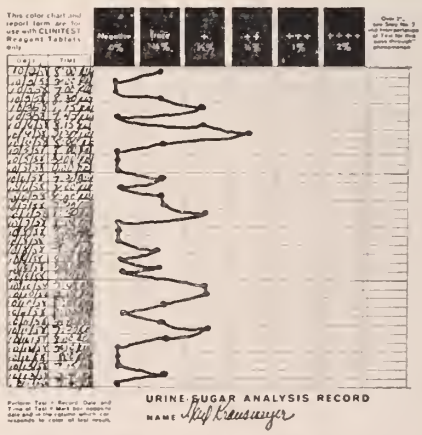
Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

A "URINE-SUGAR PROFILE" FOR CLOSER CONTROL

The new CLINITEST Urine-Sugar Analysis Set contains an improved Analysis Record form that enables even closer control of the *moderate* and the *severe* diabetic. Daily urine-sugar readings may be connected to produce a graph—a day-to-day "profile" that reveals at a glance individual trends and degree of control.

*GP *16*:121 (August) 1957.



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FOR EVEN BETTER CONTROL OF THE MODERATE AND THE SEVERE DIABETIC

the STANDARDIZED urine-sugar test for reliable quantitative estimations "...the most satisfactory method for home and office routine testing."*

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ANNOUNCING

the first "wide range" antihypertensiv

MILD MODERATE SEVER

DIUPRES*

DIURIL® WITH RESERPINE

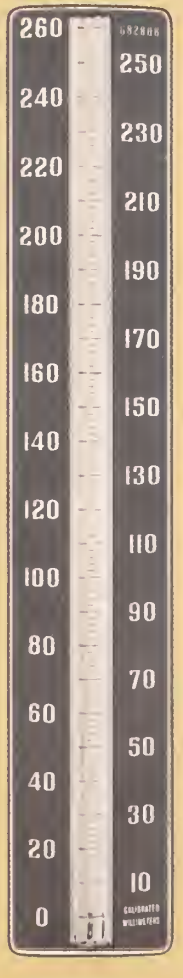
more hypertensives can be better controlled
with DIUPRES than with any other agent
. . . with greater simplicity and convenience

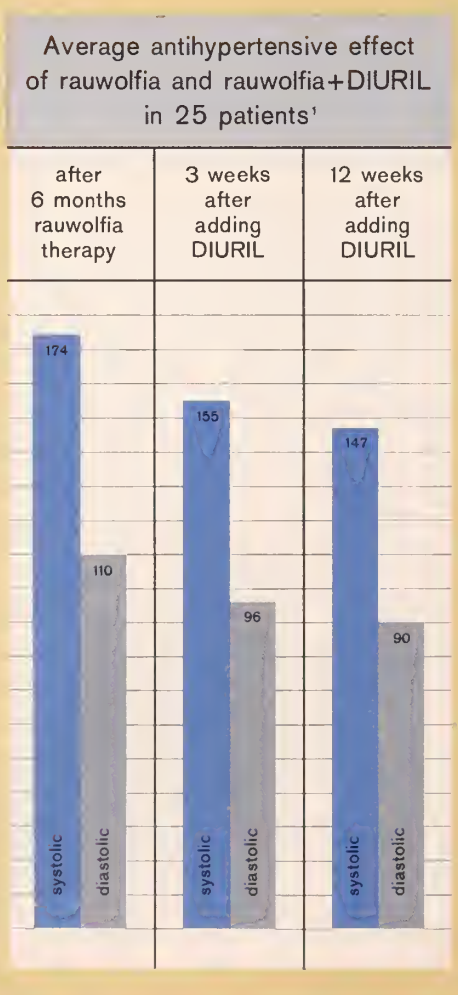
a logical alliance of two antihypertensives you know and trust provides

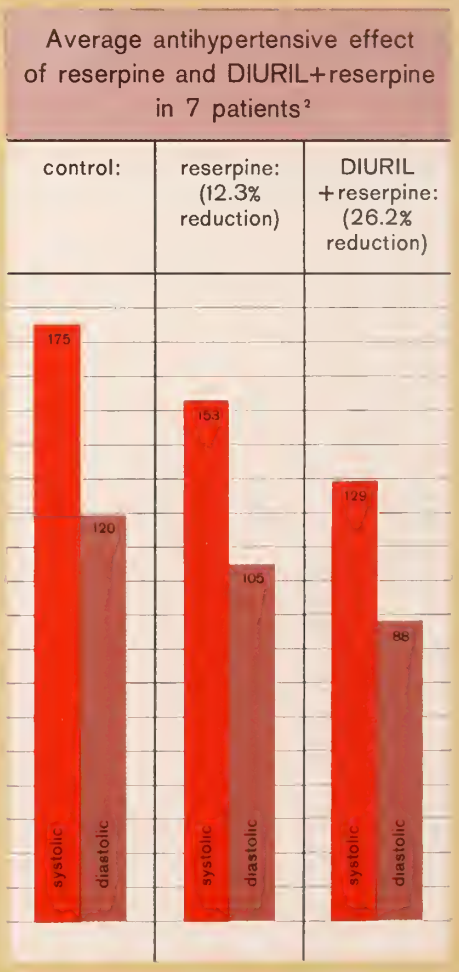
increased effectiveness, decreased side effects

potentiated effect

DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.







DIUPRES

DIURIL® WITH RESERPINE

effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause flui retention. Even when such retention is subclinical, thei antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction c dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produce the benefits of a markedly restricted low sodiu diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing th emotional component of hypertension. Organic change of hypertension may be arrested and reversed. Headache dizziness, palpitations and tachycardia are usuall promptly relieved by DIUPRES. When the *anginal syn drome* accompanies hypertension, the administration c DIUPRES may also cause diminution or even disappear ance of this syndrome concurrent with control of th hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one pre scription . . . the patient takes one tablet, rather than tw different tablets . . . and the dosage schedule is easier fo the patient to remember and follow.

> *"patients have fewer lapses and make fewer mis takes in dosage, the simpler the regimen can b made. Therefore I do not hesitate to use mor than one medicament combined in one table provided this gives approximately the correc dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were give two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

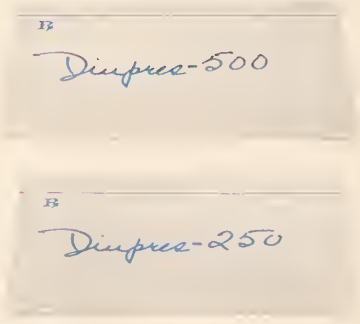
- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.
If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

DIUPRES

DIURIL® WITH RESERPINE

1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

*DIUPRES and DIURIL (chlorothiazide) are trademarks of Merck & Co., Inc



When it comes to colds and coughs, surgeons are just like their patients . . . they want relief of symptoms and, if possible, to stay on the job.

Romilar Cold Formula controls the entire symptomatology of colds, including coughs. A synergistic combination,* Romilar CF

checks coryza
suppresses coughing
relieves congestion
controls fever and malaise

this surgeon takes Romilar CF

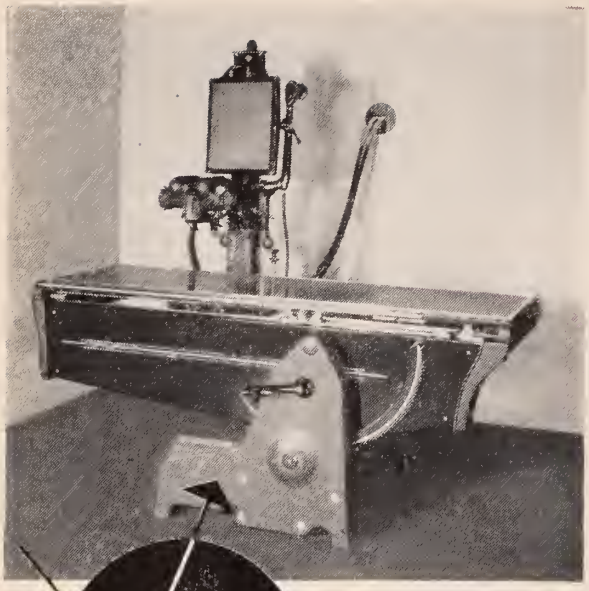
Each teaspoonful (5 cc) of pleasantly flavored syrup, or each capsule, contains: 15 mg Romilar HBr (non-narcotic antitussive); 1.25 mg Chlorpheniramine maleate (antihistamine); 5 mg Phenylephrine HCl (decongestant); 120 mg N-acetyl-p-aminophenol (analgesic-antipyretic).

*L. O. Randall and J. Selitto, *J. Am. Pharm. Assn. (Sc. Ed.)*, 47:313, 1958.

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Lysine–Vitamins

BUILDS IRON RESERVES
BOOSTS APPETITE
PROMOTES GROWTH

Each daily teaspoonful dose (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	0.75%

Bottles of 4 and 16 fl. oz.

Lederle **LEDERLE LABORATORIES,** a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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use XYLOCAINE *first...*
as a local anesthetic
or a topical anesthetic

SWAB SPRAY INFILTRATION NERVE BLOCK



Xylocaine HCl solution, the versatile anesthetic for general office surgery, relieves pain promptly and effectively with adequate duration of anesthesia. It is safe and predictable. Local tissue reactions and systemic side effects are rare. Supplied in 20 cc. and 50 cc. vials; 0.5%, 1% and 2% without epinephrine and with epinephrine 1:100,000; also in 2 cc. ampules; 2% without epinephrine and with epinephrine 1:100,000.

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(brand of lidocaine*)

Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

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even when the causative organism may be a "persistent staph"

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GLUCOSAMINE-POTENTIATED TETRACYCLINE WITH TRIACETYLOLEANDOMYCIN

increases the certainty of safe, rapid response

AS PROVED BY extensive clinical trials—an over-all success rate of more than 94% was achieved in a total of 3,280 cases.†

AS PROVED BY success in mixed infections—more than 95% of 1,000 acute and chronic respiratory tract infections were successfully treated; a 99% cure rate was achieved in mixed bacterial pneumonias.†

AS PROVED BY effectiveness in "problem infections"—a response rate better than 96% was recorded in a group of 221 gastrointestinal infections including chronic intestinal amebiasis; 91% of 465 urogenital infections were successfully controlled.†

AS PROVED BY excellent safety record—extremely well tolerated; discontinuance of medication was necessary in only 11 of 3,280 patients.†

A significant number of the above cases had not responded to other antibiotics.

Cosa-Signemycin is particularly valuable in home and office, where susceptibility testing is difficult or impractical.

SUPPLY: *Capsules* (green and white), 250 mg. and 125 mg.
New Oral Suspension (raspberry-flavored), 2 oz. bottle, 125 mg. per teaspoonful (5 cc.).
New Pediatric Drops (raspberry-flavored), 10cc. bottle, 5 mg. per drop, plastic calibrated dropper.

Average dosage: For adults, 1-2 Gm. daily in divided doses; proportionately less for children, depending on age, weight, and severity of infection.

†Literature and bibliography available on request.

*Trademark

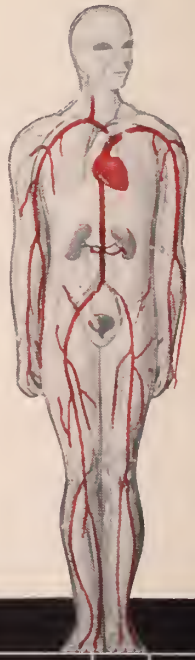
Pfizer *Science for the world's well-being* **PFIZER LABORATORIES**, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

Investigator

after investigator report

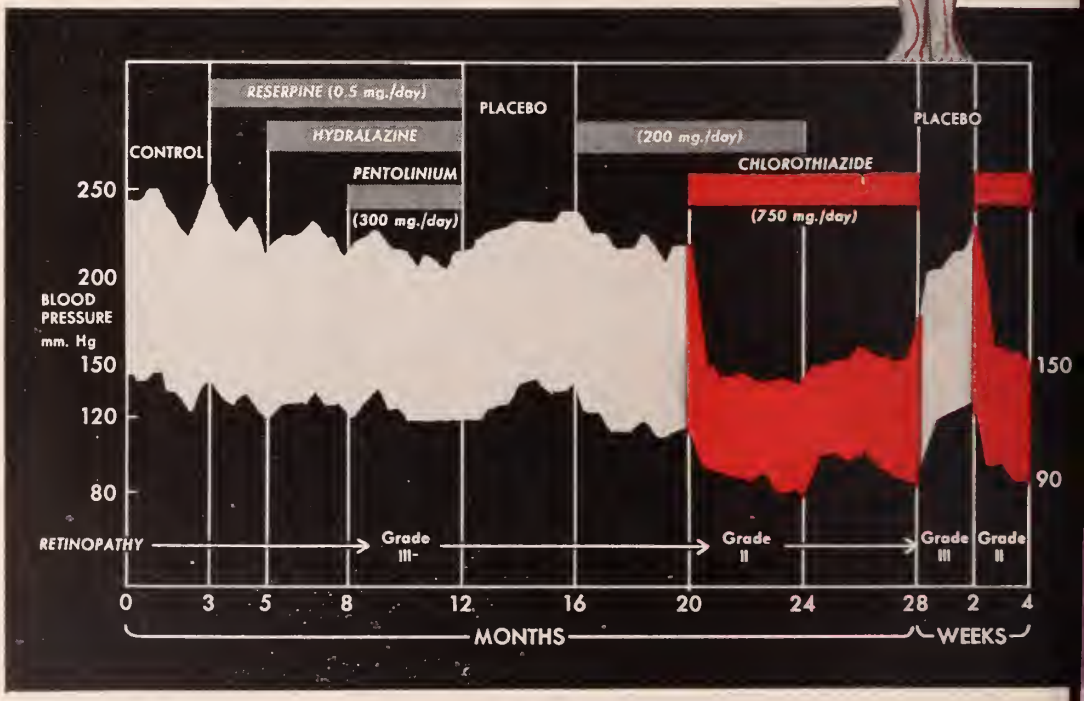
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."



Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. MSD

he effectiveness of 'DIURIL'
(CHLOROTHIAZIDE)

in

Hypertension

as simple as 1-2-3

1 **INITIATE THERAPY WITH 'DIURIL'.** 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 **ADJUST DOSAGE OF OTHER AGENTS.** The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 **ADJUST DOSAGE OF ALL MEDICATION.** The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' is a trade-mark of Merck & Co., Inc.

Smooth, more trouble-free management of hypertension with 'DIURIL'

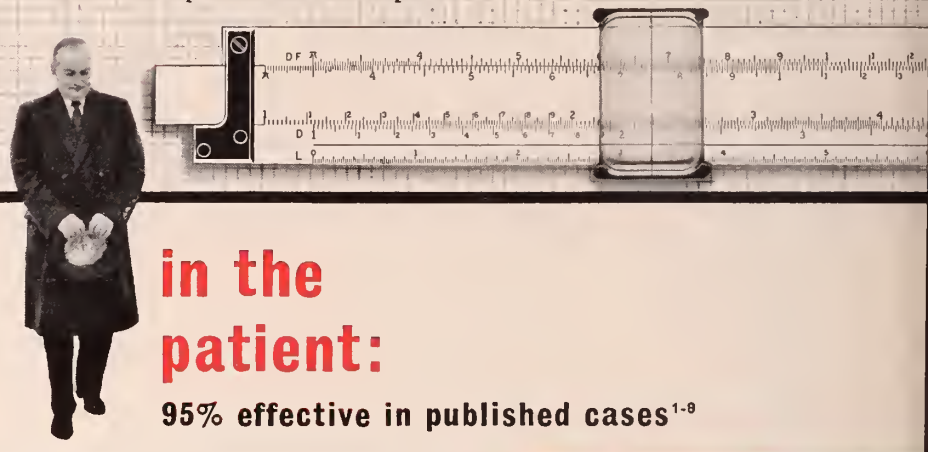
℞ PRONOUNCED TAY-O

Tao*

(triacetyloleandomycin)

Capsules / Oral Suspension

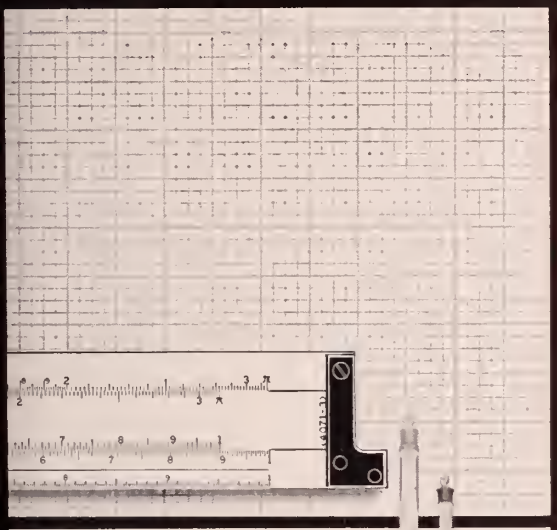
** designed for superior control of common Gram-positive infections*



in the patient:

95% effective in published cases[1-9]

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

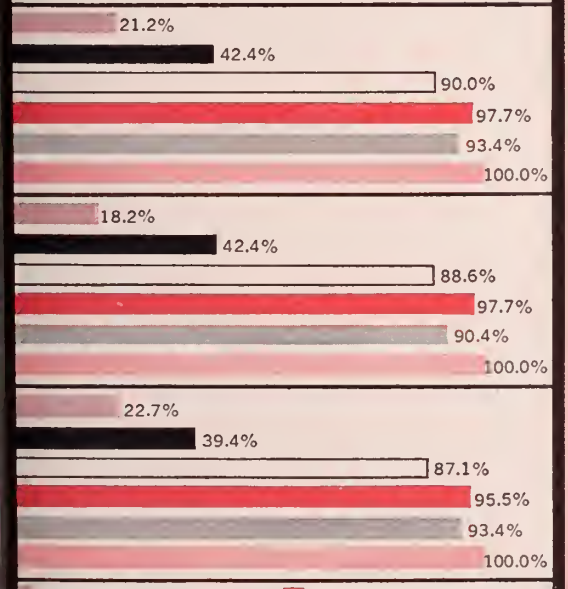


in the laboratory:



over 90% effective against resistant staph

COMPARATIVE TESTS BY THREE METHODS (DISC, TUBE DILUTION, CYLINDER PLATE) ON 130 STAPHYLOCOCCI[9]



Percentage of organisms inhibited by the range of concentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed – stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity – freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable – "practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules – 250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension – 1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

TAO dosage forms – for specific clinical situations

TAO Pediatric Drops

For children – flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers – 5 drops (approx. 25 mg. of TAO) and 10 drops (approx. 25 mg. of TAO). 10 cc. bottle.

TAO-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

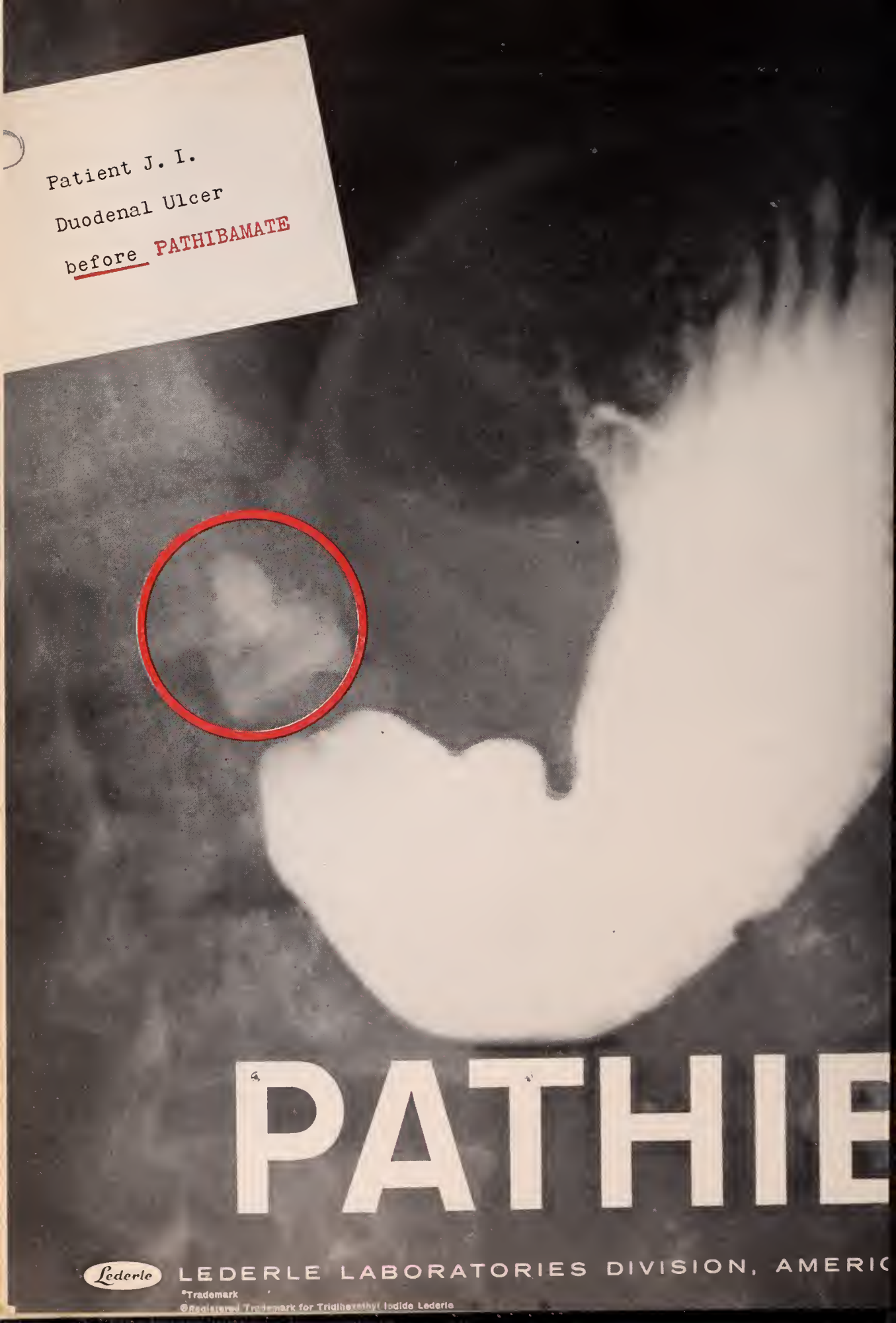
Intramuscular or Intravenous

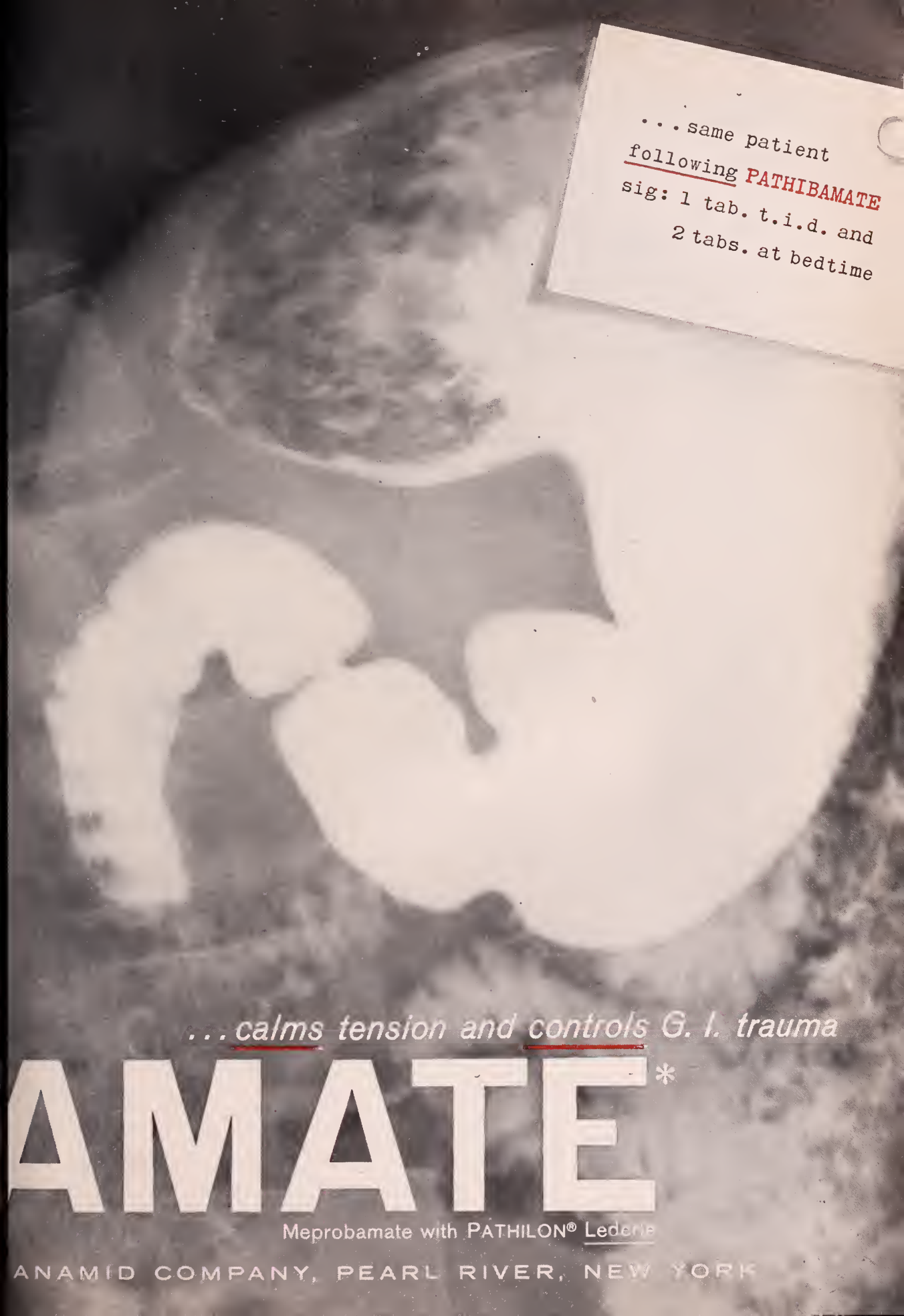
For direct action – in clinical emergencies.

Supplied: In 10 cc. vials.

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being


Patient J. I.
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before PATHIBAMATE
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sig: 1 tab. t.i.d. and
2 tabs. at bedtime
. . . calms tension and controls G. I. trauma
AMATE*
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ANAMID COMPANY, PEARL RIVER, NEW YORK

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new listening luxury for your home!

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Listen to new stereofonic music on a Webcor! You'll hear music with all its glorious tones and dimensions . . . all about you! This is listening enjoyment at its finest . . . *on a Webcor!*

See and hear the Victorian now . . . plus the complete new Webcor line for '59!



Victorian Stereo-Fidelity Radio-Fonograf plays stereo and monaural records. It features "Magic Mind" Stereo-Diskchanger, three speakers, and 15-watt amplifier, sensitive 13 tube AM-FM radio-fono combination. In hand-rubbed Mahogany. Only **$319.95**. Maple (slightly higher). Without radio **$229.95**.

Stereo Mate I—Matching external Amplifier-Speaker system for the Victorian Console. Mahogany, **$79.50**. Maple (slightly higher).

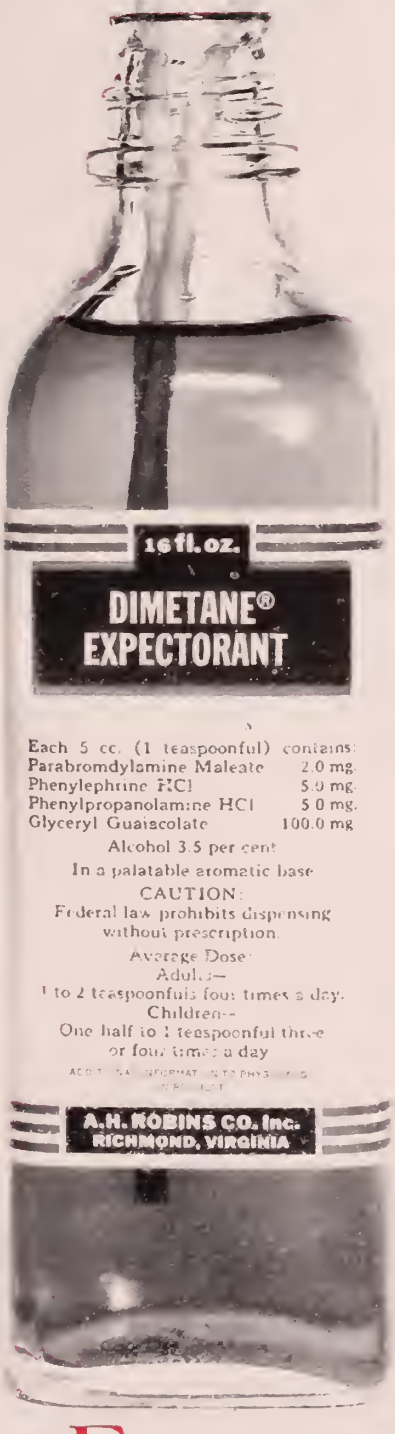
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new for cough



tastes good

the straws just symbolize the good flavor! And DIMETANE EXPECTORANT for cough is as effective as it is delicious. FORMULA: each 5 cc. (1 teaspoonful) contains: DIMETANE (Parabromdylamine Maleate) 2.0 mg.; Glyceryl Guaiacolate 100.0 mg.; Phenylephrine Hydrochloride, USP 5.0 mg.; Phenylpropanolamine Hydrochloride, NNR 5.0 mg.; Alcohol 3.5% in a good-tasting aromatic base.

works better

combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceryl guaiacolate (which increases R.T.F. almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic)

Dimetane® Expectorant
Dimetane® Expectorant-DC

Robins

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running noses



and open stuffed noses orally

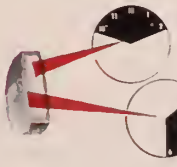
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



first —the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then —the inner core disintegrates to give 3 to 4 more hours of relief

Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

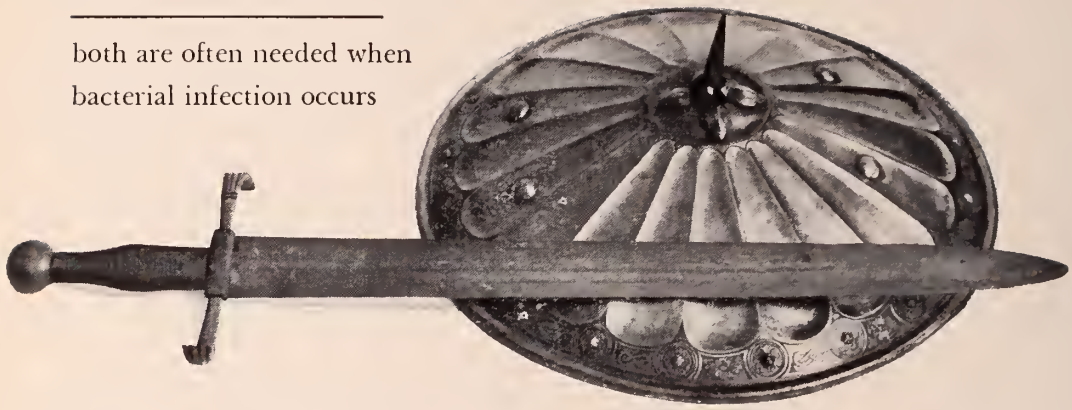
For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

▪ prompt, aggressive
antibiotic action
▪ a reliable defense against
monilial complications

---

both are often needed when
bacterial infection occurs



for a direct strike at infection

Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications

Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against Candida (Monilia) albicans.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Capsules *(250 mg./250,000 u.), bottles of 16 and 100.* Half-strength Capsules *(125 mg./125,000 u.), bottles of 16 and 100.*
Suspension *(125 mg./125,000 u. per 5 cc.) 60 cc. bottles.* Pediatric Drops *(100 mg./100,000 u. per cc.). 10 cc. dropper bottles.*

SQUIBB *Squibb Quality — the Priceless Ingredient*

'MYSTECLIN'®, 'SUMYCIN'® AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

in corticosteroid therapy of allergic diseases asthma-hay fever allergic rhinitis allergic dermatitis drug reactions



Decadron*

DEXAMETHASONE

to treat more patients more effectively

a new order of magnitude in therapeutic effectiveness
a new order of magnitude in margin of safety

Excellent and good-to-excellent results are reported[1] with DECADRON in nearly all of 362 patients with various allergic disorders, including a number of cases who had failed to respond to other corticosteroids. **No major reactions** were observed in these extensive clinical studies even after four months of continuous therapy—DECADRON produced no peptic ulcer, no diabetes, no significant hypertension, no sodium retention, no potassium depletion, no edema, no undesirable psychic reactions, and no unusual or new side effects. Less than five per cent of patients experienced minor reactions, none of which prevented continuing administration of DECADRON.

Moreover, several investigators report that side effects including [illegible] intolerance, peripheral edema, headache, vertigo, muscle weakness, ecchymoses, flushing, sweating, moon facies, hypertension, hirsutism, and acne often disappeared during therapy with DECADRON. [1]Analysis of clinical reports

Dosage: One 0.75 mg. tablet of DECADRON will replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

Detailed information on dosage and precautions is available to physicians on request.

Supplied: As 0.75 and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100.

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WALKER-GORDON LO-SODIUM MILK

Walker-Gordon Certified Milk With Sodium Content Decreased 90%
(From About 500 to Less Than 50 Mg. Per Quart)

For use in low-salt diets. **Very Important:** THIS IS A FRESH, FLUID MILK WHICH TASTES JUST AS GOOD AS THE CERTIFIED MILK FROM WHICH IT IS MADE. Paper half-pints for hospitals, quart bottles for home delivery.

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MENIC™

C.N.S. stimulant

cerebral vasodilator

in the

senility syndrome

cerebral arteriosclerosis

and **mental confusion**

Each scored tablet contains pentylenetetrazole 100 mg. (1½ gr.) nicotinic acid 50 mg. (5/6 gr.) in bottles of 100 and 500 tablets. Usual dose: 2 MENIC tablets t.i.d., p.c.

Literature and samples available upon request.

MENIC combines the mutually enhancing action of the effective analeptic, pentylenetetrazole, with the proven cerebral vasodilator, nicotinic acid.

MENIC acts to increase oxygen and blood supply to the brain and so helps to overcome the cerebral ischemia and hypoxia responsible for many senility symptoms. Produced physical, mental and social improvement.[1] Menic makes possible a more comfortable, happier life.

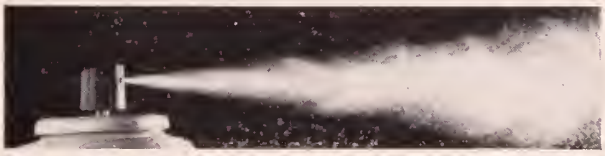
1. Levy, S.: J.A.M.A. 153:1260, 1953.

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ACHROMYCIN Tetracycline

ACHROMYCIN V Tetracycline with Citric Acid Lederle



the most widely used and useful... antibiotic



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ACHROMYCIN: Capsules • Ear Solution 0.5% • Intramuscular • Intravenous • Nasal Suspension with Hydrocortisone and Phenylpherine Ointment 3% • Ointment 3% with Hydrocortisone 2% • Ophthalmic Oil Suspension 1% • Ophthalmic Ointment 1% • Ophthalmic Ointment 1% with Hydrocortisone 1.5% • Ophthalmic Powder (Sterilized) • Oral Suspension • Pediatric Drops • PHARYNGETS® TROCHES Soluble Tablets • SPERSOIDS® Dispersible Powder • Surgical Powder (Sterilized) • Syrup • Tablets • Topical Spray • Troches

*Reg. U. S. Pat. Off.

LEDERLE LABORATORIES, a Division of **AMERICAN CYANAMID COMPANY,** Pearl River, New York

Lederle

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

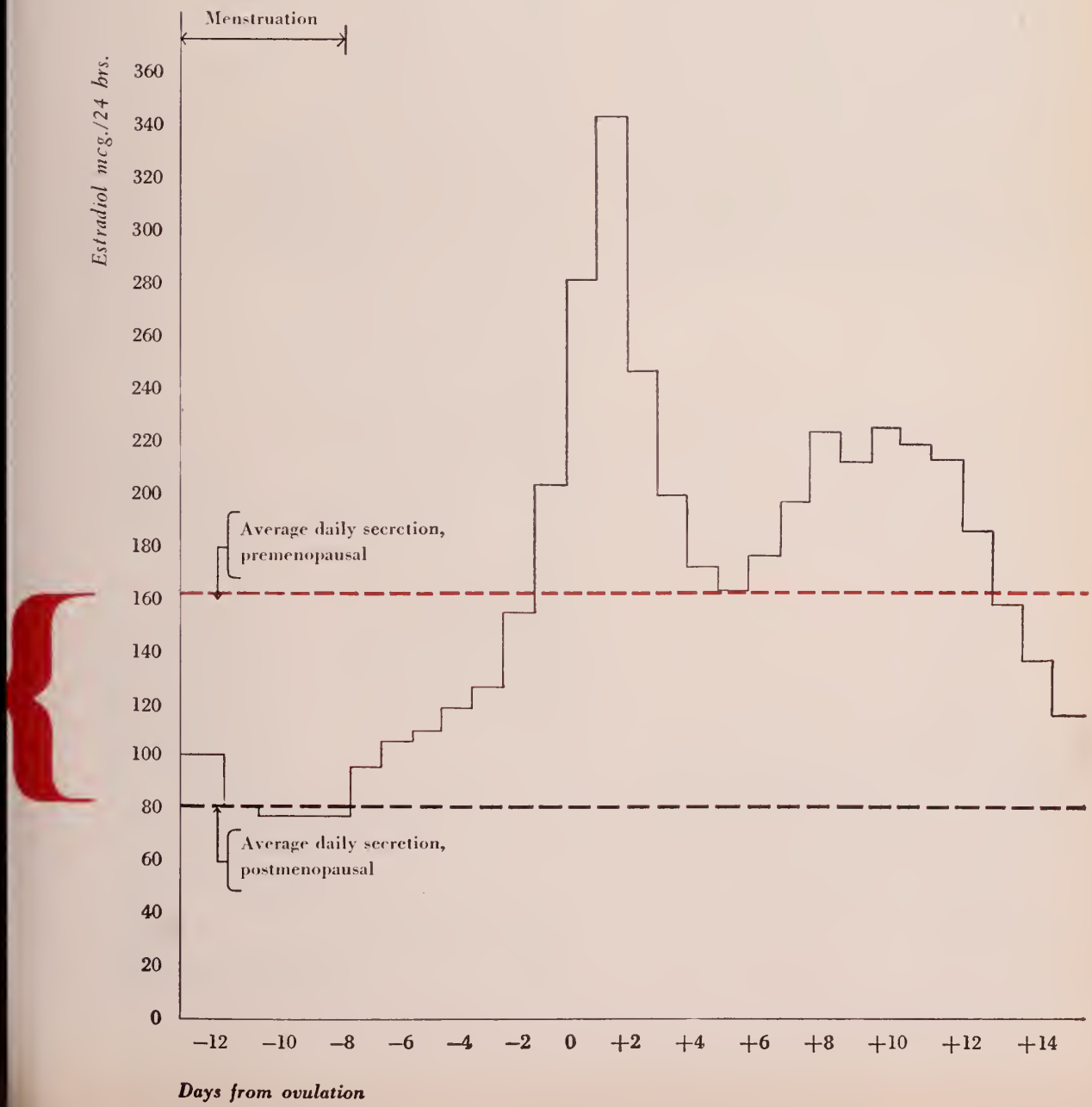
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

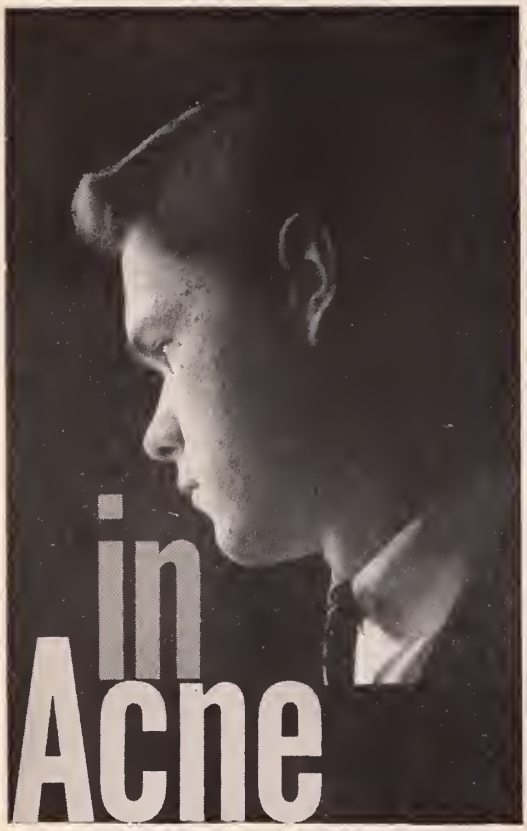
Upjohn

*TRADEMARK, REG. U.S. PAT. OFF.

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Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)





"No patient failed to improve."[1]

pHisoHex washing added to standard treatment in acne produced results that "... far excelled ... results with the many measures usually advocated."[1]

pHisoHex maintains normal skin pH, cleans and degerms better than soap. In acne, it removes oil and virtually all skin bacteria *without scrubbing.*

For best results—four to six washings a day with pHisoHex will keep the acne area "surgically" clean.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

pHisoHex®

Sudsing nonalkaline antibacterial detergent—nonirritating, hypoallergenic. Contains 3% hexachlorophene.

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New York 18, N. Y.



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



for colds of every description

one inclusive prescription

CORICIDIN® FORTE
CAPSULES

Each CORICIDIN FORTE Capsule provides
CHLOR-TRIMETON® Maleate
(chlorprophenpyridamine maleate) ..... 4 mg.
Salicylamide ..... 0.19 Gm.
Phenacetin ..... 0.13 Gm.
Caffeine ..... 30 mg.
Ascorbic acid ..... 50 mg.
Methamphetamine hydrochloride ..... 1.25 mg.

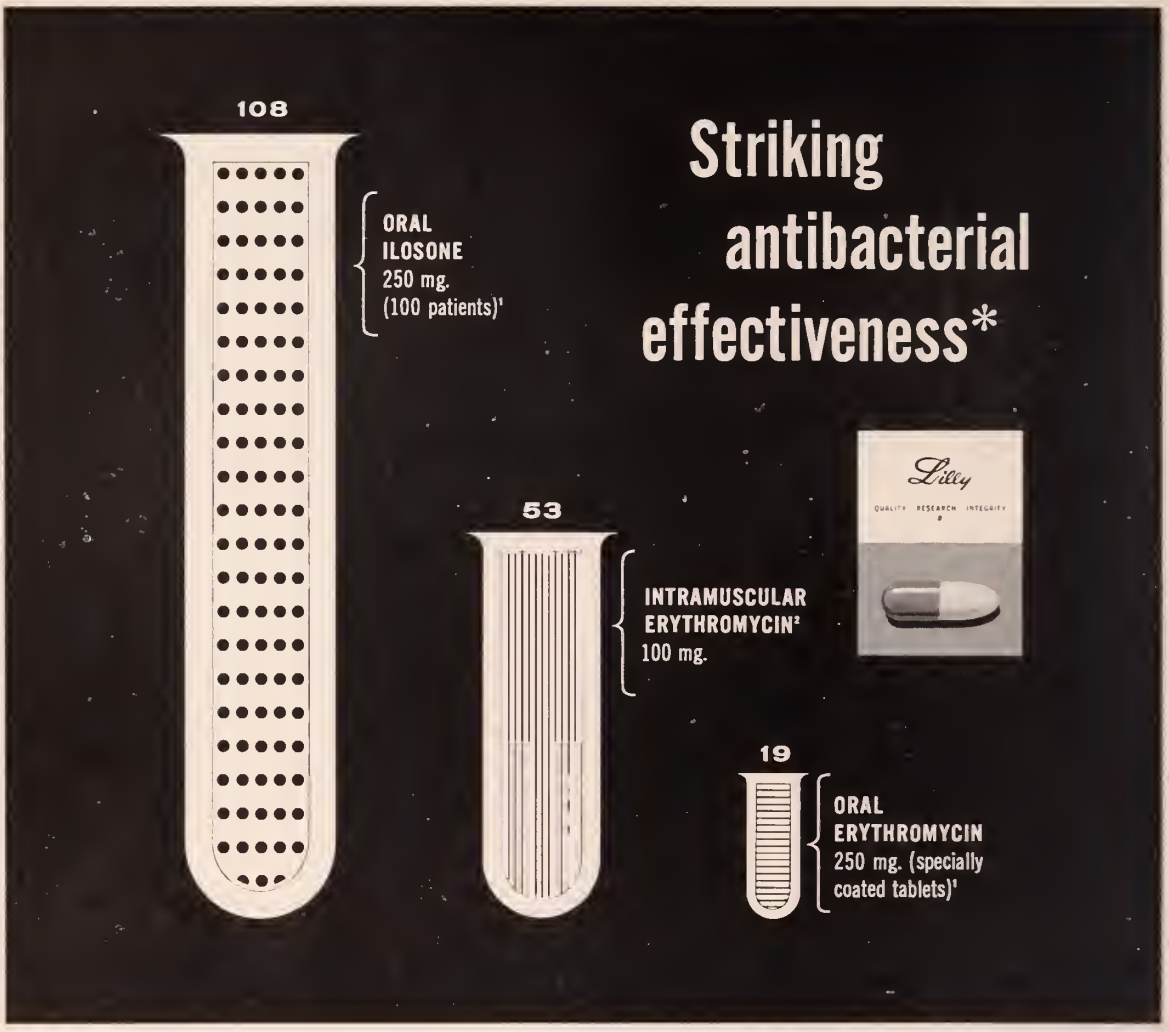
Dosage—1 capsule q. 4-6.

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1. Griffith, R. S., *et al.:* Antibiotic Med. & Clin. Therapy, 5:609 (October), 1958. Note: Peak levels with the oral erythromycin tablets (thirty-three dilutions) were not observed until four hours after administration. 2. Data from Griffith, R. S.: Antibiotics Annual, p. 269, 1954-1955.

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Editorials • • •

Medicine's Shield of Security

What are the prospects for the independent, private practice of medicine in the United States? To answer this, we must take account of many factors, some of them ominous. In a letter to our esteemed contemporary, *The New England Journal of Medicine* (April 3, 1958) Dr. Charles H. Bradford, a Boston surgeon, assesses the medical profession's basic problems in these candid terms.

"On one side," he points out, "we find ourselves threatened by state and federal programs, already operating on a large scale and eagerly seeking further enlargement. On the other side, we contemplate the ugly possibility of domination by pressure groups . . . In front of us we face the inescapable and insurmountable wall of rising costs, in which doctors' fees play only an insignificant part as compared to the staggering costs of hospitalization. Behind us we hear the hue and cry of an increasingly hostile public opinion, unleashed by demagogues who clamor for the priceless gifts of life and health at bargain rates and at the taxpayers' expense . . . "

To give us arms against this, Dr. Bradford points to Blue Shield, "one of the few constructive forward steps taken by the medical profession in the last twenty years . . . " which, he believes "may represent one of our few hopes for survival as a self-determining profession."

Blue Shield, the doctor asserts, has fulfilled its original purpose, namely, 'to convert a system of postponed payment . . . into a streamlined system of prepayment . . . " to the benefit of both the people and the profession. But now, he suggests, Blue Shield is fulfilling an even more important function. It has given us "what we as a profession never possessed before . . . an intelligently coordinated and professionally controlled corporate body through which we can bargain with the public and they with us."

Dr. Bradford writes that "if we continue to administer Blue Shield wisely, it may be all that we need to retain our professional independence." But to do so, he warns, "we

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must be willing to give as well as to receive—to regulate our practice and our fees so as to preserve our freedom from being regulated, and to grant the public as many benefits as we hope to assure for ourselves."

" . . . We, as doctors and as members of the medical society, are the managers of Blue Shield. Its success depends on us. Its failures remain our responsibility."

And, the doctor concludes: "We must grasp the larger significance of the splendid organization that we have built . . . We must stand behind it . . . not for selfish gain, but to share with the public a mutual service and benefit. In this way, and in no other, can the medical profession preserve its time-honored status as an altruistic body of men, free from the sordid controls of politics or commerce, devoting itself wholeheartedly to scientific and humanitarian tasks."

Throw Physic to the Dogs

"What rhubarb, senna or what purgative will scour the English hence?" So asked Macbeth (V.3), reflecting the high standing of laxatives in Shakespeare's time.

Rhubarb, senna and all the others! Today's medical student is told that constipation is chiefly a matter of mind under matter, and should be treated by relaxation and psychotherapy. But a generation ago, a proper medical student had to recite the long list of laxatives from aloes to zingiber. He could tell you the dose, the place of action, the color, size, shape and smell of the resulting stool, and sometimes even the contra-indications. And what a roll call it was! There were the salts: Epsom, Rochelle, and Glaubers. There was psyllium and podophyllium, agar and jalap, gamboge and rhubarb, petrolatum and then the three oils: mineral, castor and croton. He remembered cascara, calomel, colocynth, and phenophthalein too.

Take calomel. The word itself means 'beautiful black." William Gilbert had Bunthorne, the fleshly poet in *Patience* say: "How can he paint her woes, knowing as well as he knows, that all can be set right with calomel?"

Keep your powder dry and your bowels open was the advice of the primitive military surgeon of the 18th century. But laxatives go back further than that. The aloe was known to Aristotle; and to the Arabs it was so precious that it was long a Government monopoly. Hippocrates recommended cabbage as a mild laxative, castor oil as a drastic one. Magnesium sulfate made the village of Epsom famous and Queen Anne and King Charles II drank of its saline waters. Trips to Epsom attained the immortality of mention in the *Diary of Samuel Pepys.*

The medicine of those days seems so simple now. No worry about liver function, antibiotics or vitamins. No one then ever heard of electrolytic imbalance. Disease seemed to come from noxious things within, and the doctor had to remove the animalcules by purging, puking or bleeding. The big black bag included the famous British "black draught" (a senna preparation) or maybe—if the doctor had made the grand tour of the continent—a bottle of *Wiener Trank* (another senna preparation) The word *physic* was used indifferently for medicine in general and for laxatives in particular.

But now this bit of medical learning has decayed. The detail man can tell you of a laxative that neither binds nor gripes. It is firm but gentle. It strikes the patient at the most convenient time and leaves him relaxed, refreshed and relieved. It may be a bit expensive, but the patient gets a fair run for his money. It is easy to prescribe—just a scrawl on a prescription blank. No need for the doctor to learn the difference between purgatives, salines, aperients, and hydragogues. That is all gone with the wind, so to speak.

So the modern medical student agrees with Macbeth. "Throw physic to the dogs" he says.

KENNETH E. GARDNER, M.D.
Bloomfield

The Patient's Team*

While we ordinarily think of the medical team as including physicians, nurses, and technologists, there is another component of the team if the patient is in the hospital: the hospital board and administrator. Here Dr. Gardner throws the spotlight on this often neglected component of the patient's team.

THE Patient's Team consists of the trustee, the administrator and the physician. To function successfully this team must have a complete understanding of the fundamental inter-relationships which exist between the hospital administration and the medical staff.

In a general way the trustee represents hospital policy and finance; the administrator represents hospital administration and personnel relations; and the physician represents medical care and staff organization. These three comprise the major divisions of modern hospital administration with the Board of Trustees having the final authority and responsibility for all hospital administration and medical care.

The recognition of these three major divisions in hospital administration is the modern trend, but it was not always so. It has not been too many years ago—and may even exist today in some less progressive hospitals—that the trustees, the administrator and the medical staff viewed each other with suspicion, mistrust or indifference. In some hospitals in the past, the Board of Trustees and the hospital administrator did not consider the opinions of the medical staff of sufficient importance to consult with them or to include their recommendations in hospital policies on medical care. There was even a tendency to forget, overlook or ignore the obvious fact that no hospital could function for a single day without a medical staff.

This attitude sometimes bordered on open hostility and always resulted in a definite lack of harmony, unity and cooperation. This was not a healthy attitude, and was detrimental to the hospital, the medical staff and the public. This unfortunate situation, I am pleased to observe, has been—or is rapidly being—replaced by one of understanding, cooperation and a closer appreciation of the mutual problems which affect the trustees, the administrator and the medical staff. Their efforts are now being combined as a team to provide the highest quality of medical care for the people of the community which they serve.

The success or failure of the Patient's Team frequently depends upon the initiative, the incentive and the vision of one man—the president of the Board of Trustees. He must be a diplomat with the ability to create and promote goodwill and have a keen insight into the many personality variations in human relations. He must be objective in his thinking, and above all else he must be free from personal ambitions to control hospital policy. He must be easily approachable and a good listener, for it is his ability to see all problems

*Dr. Gardner is President of The Medical Society of New Jersey. This paper was read, by invitation, Sept. 24, 1958 at the Institute for Trustees and Administrators of Hospitals, assembled at Princeton, N. J.

objectively, and to recognize the personal equation in human relations, that largely determines the success or failure of the Patient's Team.

Before discussing how to improve further this new approach and relationship in the team of trustee, administrator and physician, I would like to digress for a few moments and present a brief resume of past medical progress and hospital development.

From the most ancient times until approximately 100 years ago, the treatment of the sick consisted chiefly of the care of accidents, war wounds and the use of various brews, mixtures, oils, charms and incantations. There was much misinformation due to the widespread superstitious beliefs in night air, evil spirits and curses. A great variety of concoctions were prepared, many of which included the blood and organs of animals along with the dusts of precious stones and other minerals. There was always the implication of a secret ingredient.

From the most ancient times the need for a sheltered place or building to care for the sick and injured was also recognized. These sheltered places or buildings became the forerunners of our modern hospitals. Hospitals existed in India, Persia and Arabia long before the Christian era. Their primary purpose was the relief of suffering. The care of the sick and injured was given chiefly by women who were devoted and dedicated to deeds of charity and humanitarian service. Equipment and treatment were simple. They consisted chiefly of bandages, oils, herbs and attention to hygienic measures.

Until 100 years ago the average physician had little or no use for a hospital. Nearly everything he used, he carried with him; nearly everyone he treated, he treated at home.

Rapid advances have been made during the past 100 years. The discovery of bacteria established the cause of the infectious diseases. The discovery of vitamins and the essential minerals, along with a proper diet of proteins, carbohydrates and fats developed the new science of dietetics. Rapid advances in organic chemistry have produced many new drugs which aid in the control of the infectious diseases and the deficiencies in vitamins and hormones. Additional chemical tests by laboratory methods, microscopic tissue examinations and the development of x-ray equipment have given us a host of new diagnostic procedures.

The discovery of anesthesia, the control of shock, the transfusion of blood, the prevention of infection and the use of aseptic technics all permit the modern surgeon to perform many intricate operations with safety and assurance. With these rapid advances the individual physician was no longer able to provide all the necessary services, equipment and facilities for good medical care, and thus the modern hospital was born. It has evolved today to provide a central point where the skill of the physician can be combined with the physical equipment and facilities of the hospital.

May I remind you that all our scientific advances in medicine have occurred within the past 100 years, and that this is only the beginning. More has been learned about the cause and treatment of disease, and the complicated structures and functions of the human body in the past 100 years than in all the previous 5,000 years of recorded history.

So much for the background. Now what about the present and future? With the rapid development of scientific medicine and the rapid development of the hospital as a community center to provide all the modern equipment and facilities for the diagnosis, treatment and rehabilitation of the sick, it soon becomes apparent that the modern hospital is a complex institution. Within this complex institution the Board of Trustees, the hospital administrator and the medical staff become the integral parts of a team which are interdependent and inseparable. Each plays an essential role in the care of the sick of the community.

However, regardless of its size or complexity, the quality of medical care within the hospital must be the first responsibility of the Board of Trustees, the hospital administrator and the medical staff. No modern hospital administration can carry out its responsibilities

successfully unless there is complete cooperation and understanding among these three major groups.

How then can we achieve this complete cooperation and understanding? It is essential to recognize that each of these three groups is comprised of a wide variety of individuals with highly specialized skills and training. Not only does this apply in the field of medicine but equally so in the fields of business administration, finance, law, economics, political science, social welfare and many others. Although the primary purpose of the hospital is to provide the highest quality of medical care, it must also operate on a sound business basis. Therefore, the modern hospital must utilize all of its available talents.

EVERY hospital must have a governing body which is usually called the Board of Trustees. This board has both a legal and moral responsibility to the community for the quality of medical care and everything else that goes on within, or is connected with, the hospital. In addition to medical care it must also constitute the final authority on all matters of hospital administration such as policy, finance, public and personnel relations and maintenance.

No Board of Trustees, regardless of how well trained it may be in administration, would consider itself competent to judge the quality of medical care in the hospital or the qualifications of the medical staff. In most instances, the Board of Trustees is comprised of non-medical, but public spirited citizens, who are not trained in the highly technical problems of medical care. Neither are they trained in the intricate problems of daily hospital administration. However, since the Board of Trustees has the responsibility for both medical care and daily hospital administration, it becomes essential that it is adequately advised at all times by those persons who are best qualified in these respective fields.

To establish and maintain a high quality of medical care, the Board of Trustees must depend upon the recommendations of the medical staff or its representatives concerning technical problems and medical procedures. It must also depend upon the recommendations of the hospital administrator concerning matters of maintenance, equipment, personnel and the daily problems of hospital administration. I should like to emphasize at this time that the problems of medical care and those of general hospital administration, although intimately related, are two separate and distinct functions, and although equal in importance, each should be a direct function of the Board of Trustees.

In some hospitals all the recommendations of the medical staff for medical care must first be presented to the hospital administrator for his consideration. If they meet with his approval, they are then presented by him to the Board of Trustees. With all due respect to our many well-trained, efficient and hard working hospital administrators, I believe that most of them would readily agree that they are not always qualified to judge the technical problems and medical procedures involved in medical care; and furthermore, that most of them would prefer to have the problems of medical care presented directly to the Board of Trustees by qualified members of the medical staff.

ON ALL matters of medical care, however, the hospital administrator should be first advised of the recommendations of the medical staff. Many of the day to day problems of medical care and hospital administration are so intimately related that only by close cooperation and understanding can the best results be achieved. It is suggested that after consultation with the hospital administrator the problems of medical care should be presented directly to the Board of Trustees by the representatives of the medical staff.

Since the Board of Trustees is usually composed of non-medical persons; since the hospital administrator is usually not a physician, or if so, is not directly associated with patient care; and since the problems of medical care are usually highly technical and can only be properly resolved by the medical staff, I would like to strongly urge that at least two members of the medical staff become voting members of the Board of Trustees.

One of the major advantages to the Board of Trustees in having members of the medical staff on the Board is that the physician-trus-

tees are immediately available to provide the Board with their experience and judgment on matters of medical policy. These physician-trustees can also present the recommendations from the medical staff directly to the Board. In turn, and of equal importance, the Board can advise the physician-trustees of the other problems which confront the hospital administration. This close relationship promotes better understanding and cooperation between the hospital administration and the medical staff. This arrangement is already in operation in some hospitals and has been found to be mutually beneficial to all parties concerned.

Assuming that at least two members of the medical staff should be voting members of the Board of Trustees, they should be representatives of the active medical staff. It is desirable to have these physician-trustees the same physicians who have been elected to the two highest staff offices. These are usually the president of the staff and the president-elect or vice-president. Provision should be made in the Constitution and By-Laws of the hospital to permit these two elected officers of the staff to become physician-trustees during their respective terms as elected staff officers.

No reference to a Medical Director has been made to this point because many hospitals do not have one. If a Medical Director is used, he usually becomes the liaison representative between the Board of Trustees and the medical staff. He frequently has authority granted to him by the Board to supervise medical care and medical policies. He should be a member of the active medical staff and in the spirit of unity, cooperation and harmony, he should be chosen by a joint committee composed of an equal number of members from the Board of Trustees and the medical staff. After his selection by this committee he should be jointly approved by both bodies and become one of the physician-trustees of the Board. The other physician-trustee should be the president of the medical staff during his term of office.

The Board of Trustees frequently has an executive board to which one of the physician-trustees should be appointed. The hospital administrator should also attend the executive board meetings. He is usually not a voting member but is valuable as an advisor and may act as secretary.

In like manner, the medical staff frequently has an executive board on which both physician-trustees should be members.

These two executive boards have another valuable function. In order to promote unity, cooperation and understanding between the hospital administration and the medical staff, there is a definite need for a Joint Conference Committee. I would like to endorse a similar recommendation by the Joint Commission on Accreditation of Hospitals. This committee should be composed of the executive members of the Board of Trustees, the executive members of the medical staff and the hospital administrator and his associate staff. The purpose of this committee is to discuss informally the day to day problems which relate to medical care and hospital administration. The frequency of meetings will vary from one a week to one a month depending upon the number and nature of the problems.

This Joint Conference Committee can discuss the many inter-relationships between medical care and hospital personnel as nurses, technicians, dietitians, social workers and many other services. It can also be helpful to the full time or part time physician-administrators in such departments as x-ray, laboratory and physical medicine. These physician-administrators have a dual responsibility. For the administration of their departments they are responsible to the hospital administrator; for their professional services they are responsible to the medical staff. They have many problems which deal with medical care as well as administration. They must constantly be aware of new equipment, new procedures, new treatments and the related problems of personnel.

The Joint Conference Committee provides an ideal group to discuss the mutual problems which affect the Board of Trustees, the hospital administrator and the medical staff. These informal discussions frequently result in recommendations which can be formally presented to the Board of Trustees for final ac-

tion. These joint conferences create a general feeling of harmony, unity and cooperation.

There is one further subject which is vitally important for it relates to all the people and all the qualified physicians in the hospital area. If you will accept the principle that a general hospital in any community exists to serve all the people in that community, then it should follow that all the qualified physicians in the same community are entitled to receive hospital courtesy staff appointments to care for these same people. There is a tendency in some hospitals either by action of the Board of Trustees or the medical staff to restrict the number of physicians on the hospital staff with the erroneous explanation that increasing the number of physicians on the staff will increase the number of patients in the hospital and thus produce overcrowding.

May I emphasize again the principle that if the hospital exists to serve all the people in the community or hospital area, then restricting the number of local qualified physicians on the courtesy staff will not change the number of people in the community who require hospitalization. It does only one thing—it denies the patient the right to choose his own physician while in the hospital. The patient still goes to the hospital. The only change is that he must now choose a physician who has an appointment on the hospital staff.

It is my belief that every qualified physician, who practices in the hospital area, should be granted courtesy privileges to care for the people of that area. To do otherwise makes membership on a hospital staff a special privilege which is granted to a select group. This special selection of a hospital staff does not serve the best interests of all the people of the community. This is particularly true in those communities where the hospital is partly supported by private contributions, community chest or by county and municipal welfare funds. Special selection of a hospital staff can only be justified in a privately owned and operated hospital which receives no public support.

In some hospital areas this attitude of mutual community service between the local hospital and the local physicians has already been recognized. By action of the Board of Trustees all local qualified physicians are granted courtesy privileges after approval of the physician's credentials by the proper credentials committee and the medical staff. The extent of privileges in each department as medicine, surgery and obstetrics is the direct responsibility of that department.

Although the Board of Trustees has the final authority to appoint the medical staff, the qualifications of the physicians applying for staff privileges can only be determined by other physicians. Thus, the decision of the Board to grant appointments, promotions, and privileges must first depend upon the recommendations of the medical staff. I should like to make one final suggestion that all appointments, promotions and privileges once granted should be permanent, and although they should be reviewed yearly by the medical staff and the Board of Trustees, they should not be revoked or reduced without due cause.

In conclusion, it has been my purpose to present the inter-relationships of hospital administration and medical care and to make recommendations which will produce the greatest amount of harmony, unity and cooperation in the Patient's Team of trustee, administrator, and physician.

It has been pointed out that the Board of Trustees has the responsibility to the community for medical care and all matters of hospital administration; that the quality of medical care is the responsibility of the medical staff; that daily hospital administration is the responsibility of the hospital administrator; that medical care and daily hospital administration, although intimately related, are two distinct functions of the Board of Trustees; and that the key man in the success or failure of the Patient's Team is usually the president of the Board of Trustees.

It is recommended that at least two members of the active medical staff be voting members of the Board of Trustees and that at least one physician-trustee be appointed to its executive board; that if a Medical Director is

used, he be selected by a joint committee of the Board of Trustees and the medical staff and approved by both and that he be a voting member of the Board of Trustees; and that the physician-trustees be members of the executive board of the medical staff.

It is further recommended that a Joint Conference Committee composed of the executive members of the Board of Trustees, the executive members of the medical staff and the hospital administrator and his associate staff meet informally at regular intervals to discuss the day to day problems of hospital administration and medical care.

And finally, it is recommended that all qualified physicians in the hospital area be granted courtesy privileges to care for the people in the same area; that all appointments, promotions and privileges once granted should be on a permanent basis and that although they should be reviewed yearly by the medical staff and the Board of Trustees, they should not be revoked or reduced without due cause.

Medical science and the need for additional hospital facilities will continue to increase each year. As the need for more medical care and greater hospital facilities expands we must constantly think ahead and recognize that the hospital of the future will be a more complex institution than it is today; that there must be an attitude of continuous community service behind all administrative decisions; that medical progress will continue its rapid advances; that there will be more specialization with the establishment of new departments; and that there will be a need for new equipment and trained personnel.

However, it is not the material building of brick, mortar, equipment and size that makes a hospital great, but the mutual respect, the interest, the understanding and the goodwill which exists among the members of the Board of Trustees, the hospital administrator, the hospital personnel and the medical staff. It is this mutual respect, interest, understanding and goodwill which create the incentive, the harmony, the unity and the cooperation which are so essential to build a great hospital.

And finally, we recognize, that it is team work among the Trustees, the administrator and the medical staff which builds the greatest team of all: The Patient's Team.

45 Fremont Street

Bad Guess

The government, while slow to acknowledge anything wrong with the Social Security System, underestimated the demand for benefits. Women who could obtain benefits at 62, 63, and 64 decided to do so even if the payments were less than they would be at 65. Farmers suddenly turned out to be older than expected. Some began to pay social security taxes on reported income of $4200 which exceeded their income in prior years. Then they applied for benefits after paying taxes for six quarters. Many people who had retired and were well beyond 65 years of age, dug up jobs for themselves and paid social security taxes for 18 months, thereby qualifying for benefits of from $30 to $108.50 monthly for life. Social security experts in making their cost projections underestimated the ingeniousness of the American people when federal give-aways are as widely advertised as are social security benefits.

(A.M.A. Department of Public Relations)

Howard B. Miller, M.D.*

Fairlawn

The Expanding Frontier of Cytology

No weapon should be neglected in the war on cancer. Cytology has made giant strides in the past twenty years and, as Dr. Miller shows here, is now a valuable adjunct to the more traditional technics of cancer detection.

The value of cytology in cancer detection as championed by Papanicolaou is now well established. The study of cytologic changes as well as histologic architecture is extremely important in the diagnosis of malignancy. It is, indeed, expanding into many fields. Cytologic study and interpretation are fast becoming additional tools in the diagnostic equipment of the clinician.

The cytologic method has the added advantage of being simple, inexpensive and nontraumatic. It does not necessarily require the hospitalization of the patient or the use of laboratory animals.

The effectiveness of cervical cell studies for the detection of early asymptomatic cervical cancer in either the early invasive or the preinvasive stage has been well documented and is now generally accepted. Below I will present the new uses of this most valuable diagnostic tool which will be of interest to the general practitioner as well as the specialist.

STOMACH AND INTESTINES

Slow progress has been made in the early diagnosis of cancer of the stomach. X-ray studies fail to detect many early carcinomas and lead to false negatives in some and positives in others. There is obvious need for an additional method to be used in conjunction with x-ray studies. Cytologic study of gastric secretions is an important aid in filling this need.

Studies of gastric material collected from the stomach by means of the gastric abrasive balloon produced accurate positive reports in 66 per cent of a recent series of 117 patients with known gastric cancer, not including 19 per cent in whom the results were termed "suspicious." In 15 per cent of the gastric cancer cases, no tumor cells were found in the smears, and one positive test was found in the group of 485 patients without demonstrable gastric cancer. Comparing these results with those obtained by roentgenograms, it was found that of the 114 patients with gastric cancer who were examined by both technics, 67 per cent were correctly read cytologically while 68 per cent were correctly reported by x-ray studies. However, each method detected cancers missed by the other, so that by using the two methods together a total of 89 per cent were correctly diagnosed as positive for gastric neoplasms.

The false negatives obtained by both technics (cytology and x-ray) can usually be accounted for on the basis of the size of the lesion, its location (antral, mucosal, submucosal) and the surface characteristics (ex-

*Dr. Miller is Director of Cytology for the Paterson Board of Health.

ample: overlain by necrotic material). The incidence of correct positive cytologic reports in patients having carcinoma of the stomach indicates room for improvement. But the figure is, at least, comparable to the result obtained by x-ray studies. This by no means implies that one method should supplant the other. They should compliment each other, for they can reveal cancers of different types and places. The *additional* use of cytology in the field of detection of early cancers of the stomach is emphasized.

Similar studies indicate rectal and sigmoid washings to be of invaluable aid in helping to detect carcinomas of the rectum, rectosigmoid, and sigmoid regions. This is especially true where x-ray studies, sigmoidoscopy, and biopsy yield equivocal results due to the distortion caused by such lesions as multiple diverticulosis or diverticulitis. Cytologic studies of washings from these areas often reveal malignant cells and help clarify the issue. The method is easy and painless. It should be an adjunct to the total care and study of these patients.

PERNICIOUS ANEMIA AND CANCER

Carcinoma of the stomach is more frequent in persons with pernicious anemia. The cytologic characteristics of pernicious anemia cells are now well defined. Further follow-up cytologic studies have revealed a relationship between the pernicious anemia cells and a morphologic trend of these cells to malignancy. This cannot be ignored. Periodic gastric drainages and cytologic study of these secretions are certainly indicated. These have been instrumental in detecting early carcinomas of the stomach before clinical suspicions were even aroused.

PANCREAS AND BILIARY TRACT

Results of five-year follow-up studies on a series of carcinomas of the pancreas and biliary tract have shown cytology to have a definite place in the battery of laboratory tests needed to detect these conditions. Duodenal drainage obtains secretions from three main sources: Biliary tract, pancreas, and duodenum in region of the sphincter of Oddi. Malignant cells from any of these can often be demonstrated by cytologic study of the secretions obtained from duodenal drainages. Duct obstruction is a limiting factor. But complete duct obstruction is not always present, and even so, single exfoliated cells may get through. Other laboratory work, including x-ray studies are far from adequate in actually determining the presence or absence of cancer in these areas. Malignant cells cannot *always* be demonstrated cytologically; but the point is that they may be. It is certainly worthwhile to do this rather simple test. Duodenal drainage is a simple, old and tried method of obtaining secretions from the duodenal, biliary and pancreatic areas. Cytology should be applied to this older method for an intensified assault on these problems. It should certainly be included in the workup of these cases. Malignant lesions of the sphincter of Oddi, the gall bladder, and the pancreas have been detected by cytologic study of duodenal drainages, preoperatively and proved postoperatively. Since such a simple diagnostic procedure exists, it is unwise to neglect this procedure among the others.

BREAST MALIGNANCY

In some women, the chief complaint is discharge from the nipple. In many instances a mass will not be palpable. It is impossible in such instances to determine if a benign or malignant lesion is causing this discharge. It is negligence to assume that the cause is benign until all cancer detection methods have been utilized.

Smears of breast discharge are easy to obtain, prepare and study. If (and this is true of all laboratory methods) the smears are negative for malignancy, then certainly nothing was lost. If malignant cells are found, an early diagnosis can certainly be established and proper therapy carried out before a palpable mass develops and the extension of the lesion occurs.

In the presence of a palpable mass, surgical intervention and identification of the mass are indicated. However, a surgical specimen may not always be obtained from the malignant area. A negative pathologic report on the specimen obtained may lead to erroneous conclusions. A positive breast smear, if found, will alert the surgeon and pathologist to seek in other questionable areas for tissue confirmation.

Castration is justified only in women whose carcinomas have extended beyond the confines of the breast and who are relatively resistant to x-ray therapy. The fact that a woman is in the post-menopausal age group and has amenorrhea (even of years' duration) does not mean that complete cessation of estrogenic function has occurred. It is often clinically impossible to determine if ovarian activity is present in these cases.

Cytologic studies of vaginal secretions will help clarify this. The vaginal cytology will reflect estrogenic function directly and in proportion. If the cytologic studies of vaginal secretions reflect good estrogenic function, castration is indicated to remove this hormonal source of tumor stimulation. If cytologic studies reflect complete absence of ovarian activity, then it is questionable if anything is to be gained by castration procedures.

If castration is carried out, cytologic studies of vaginal secretions are of great aid in evaluating the physiologic effect of such procedures. Periodic smears taken postoperatively or post radiation will certainly indicate whether estrogenic function has been affected or is on the decline. Such information can be used to great advantage clinically in determining future therapy and prognosis.

LUNG MALIGNANCY

LATE diagnosis is still the primary obstacle to lung cancer survival. Early examination of sputum from deep cough specimens is a reliable and accurate diagnostic method for carcinoma of the lung. The examinations usually require three deep cough sputum specimens on five successive mornings. Such examinations have revealed carcinomas in places which were inaccessible to the bronchoscope. Where an entire area was in question, the exact place to obtain a biopsy is difficult to determine. Negative biopsies have been obtained from a malignant region. Here a cytologic study aids materially in the obtaining of a much wider random specimen of cells. This has very often proved to be the case where the lesions exfoliate into the bronchial tree from the smaller bronchioles. In other cases exfoliated malignant cells have been found in the main bronchus, not detected by the bronchoscope simply because they were overlain by inflammatory areas and the biopsy did not reach the malignant points. It is not my purpose to compare the value of bronchoscopy to cytology but simply to emphasize the importance of using the two methods together. Cytologic study should be used with these other known methods to detect early cases of lung carcinoma. It may help to reveal many silent inaccessible regions of malignant activity.

AN INDEX OF OVARIAN ACTIVITY

THE proportion of cornified squamous cells in the total cell count varies with the amount of estrogen utilized in the body. Conversely, the ratio of basal cells varies with the degree of atrophy of the vaginal epithelium. The functional state of the ovaries can be evaluated by studying the proportion of each type of cell present in the smear. Periodic vaginal smears are of value in assessing progress in the management of the menopause by estrogens. They will also help in the follow-up of patients being treated by hormones to prevent excessive use of such therapy.

Cytologic study in functional bleeding can also be a great help in differentiating between withdrawal bleeding, overtreatment with estrogen, and an early undetected malignancy.

CARCINOMA IN YOUNG WOMEN

CARCINOMA of the cervix has a higher incidence among the younger age group than had generally been assumed. Reliable and accurate studies of presumably asymptomatic

women from whom routine Papanicolaou smears were taken, showed an incidence of carcinoma of the uterine cervix of about 1.5 per cent. Of these 34 per cent were less than forty years old, and the cancer was invasive in about 50 per cent. Thus, in about 50 per cent of patients with malignancy (each less than forty years of age) cancer had already progressed beyond the superficial intraepithelial stage.

Routine Papanicolaou smears are an effective diagnostic aid in such cancer detection. Carcinoma *in situ* especially is readily detected. There is well documented cytologic evidence proved by histologic study that:

(A) Carcinoma *in situ* and invasive carcinoma may exist in the same diseased cervix. When cytology reveals malignant cells and the biopsy is reported as carcinoma *in situ*, one should note that other portions of this cervix, not biopsied, often contain invasive carcinoma.

(B) Areas of leukoplakia are often associated with carcinoma *in situ* or invasive carcinoma of the stratified squamous epithelium beneath the layer of keratin.

Thus, the finding of malignant cells with the cytologic method should be given its due regard and not treated lightly, simply because the report of carcinoma *in situ* or leukoplakia is given following the biopsy. Of course, the biopsy specimens may show only such pathology, but deeper and more extensive carcinoma may exist in other portions of the same cervix which is making itself known only by their exfoliated cells. In these cases conization of the cervix (cold scalpel) with careful serial sectioning should be done before a final conclusion is reached.

The point to be emphasized here is that in a diseased cervix, inflammatory cells, carcinoma *in situ*, leukoplakia, and invasive carcinoma may exist side by side, and that cytologic study could be of utmost importance in detecting such cases.

FEMALE GENITAL TRACT

IN MALIGNANT conditions of the genital tract such as Paget's disease of the vulva, cancer of the vulva, squamous cell carcinoma of the cervix, endometrial carcinoma and carcinoma of the ovaries, vaginal smears were taken and studied cytologically. The cornification index was recorded. The cornification index is the number of cornified cells per hundred squamous cells counted.

Accurate forecasts relying on these cornification readings were made in 90 per cent of 165 patients of a recent series studied. Those with a cornification index over 10 either had pathology at the time of examination or developed it within a six month period. A low cornification index reading, below 10, during the observation period after completion of treatment should be regarded as a favorable prognostic sign.

Cornification index estimation in patients who received radical treatment for malignant disease of the genital tract seems to be of great diagnostic help in the recognition of failure of response or in the detection of early recurrence. Cornification estimations therefore should be included in the routine cytologic follow-up investigation of cancer, in view of the implications of these and other such tests.

Recently, a new, simple and reliable method of intra-uterine washings has markedly increased the yield of positive findings in carcinoma of the endometrium by cytologic study. This was previously a difficult area from which to derive exfoliative material.

CARCINOMA OF THE CERVIX AND RADIATION EFFECT

BASAL cell activity after irradiation of cervical cancer is probably one of the most accurate responses to therapy.

Radiation response (R.R.) is determined by studying benign vaginal epithelial cells for vacuolization of the cytoplasm, nuclear chromatin changes and multinucleation. R. R. is considered good if 75 per cent of normal cells show any of these changes. The effect of radiation and prognosis are even better if this response to radiation consists of at least 45 per cent basal cell changes. If radiation response and basal cell response differ, the basal

cell response total has been shown to be the more accurate prognostic sign.

Thus, not only radiation effect on malignant cells can be determined, but also cytologic study of its effect on the benign cells has proved to be of great value. Actual cytologic destruction by radiation of malignant cells can be observed. Follow-up studies give us a microscopic series, enabling us to detect quickly the re-appearance of malignant cells or the persistence of malignant cells.

SUMMARY

Cytology as a diagnostic aid is of much value in the early detection and follow-up of cancer. Its application in wide fields (stomach, lung, biliary tract, rectum) is discussed. The importance of cytologic study before and after radiation as a means of evaluation of radiation and also as a means of prognosis is presented. Cytologic study should be used as an adjunct to other established laboratory and x-ray procedures.

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Modern-Day Tomahawk Wound

The case of a modern man who suffered a tomahawk injury and was treated by a prehistoric method is reported by an Iowa physician. Writing in the November 1958 Archives of Internal Medicine, Dr. Thomas B. Summers, Iowa City, said the head injury was treated by trephination. Trephination was practiced extensively by prehistoric South American Indians.

The patient was a 57-year old man who operated a trailer camp. He was struck on the cheek with a tomahawk after he had stopped a resident of the camp from beating his wife.

Two weeks after being hit, the patient began having pain in both temples. During the next weeks he experienced increasing waves of pain in the head. At times his fingers, tongue, and lips became numb. After a severe attack of pain during which he also could not speak for 30 minutes, he went to the doctor. During examination he experienced numbness and weakness of the left hand and forearm. The picture suggested a subdural hematoma.

Holes were made on both sides of the skull and c.s. fluid removed. He remained in the hospital for nine days. During the next month, he was readmitted to the hospital twice for removal of more fluid from the skull cavity. Seven months later, a further brain operation was performed. Now two years later, he is free of symptoms and is working.

Trephination was performed by the Incas to treat wounds from a macana, a wooden weapon edged with sharp flint, and also to allow "evil spirts" to escape from the head. American Indians also performed the operation to treat tomahawk wounds.

In Peru and Bolivia, at least one skull has been found with signs of five successful trephinations. With rare exceptions, the operation among the Indians was followed by normal healing. The native surgeons apparently had knowledge of liquids and powders that acted as antiseptics.

If the Iowan had not had the benefit of modern surgical treatment, he would have died and been buried in some contemporary cemetery. As it is, sometime in the distant future an archeologist may come across a skull showing signs of a tomahawk wound and trephination and "speculate upon the anachronism of tomahawk injuries in the 20th century."

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Coagulation Defects and Pregnancy*

Dr. McElroy here makes an eloquent plea for more complete hematologic studies in cases of obstetric bleeding and cases of "obstetric shock." He offers practical pointers for the management of these emergencies.

Coagulation defects as a cause of obstetric hemorrhage and "obstetric shock" have assumed an increasing role in the care of patients with the complications of abruptio placentae, dead-fetus syndrome, hydatid mole, toxemia, abortion with sepsis and amniotic-fluid embolism. Maisel and Cartnick [21] have placed the incidence at about 1 in 3000 deliveries. My own experience, however, would increase this to about 1 in 750 deliveries.

The nature of these defects is best described by the term "defibrination" as suggested by Page [25] and adopted by Schneider.[39] Synonymous terms are: afibrinogenemia, hypofibrinogenemia, fibrin embolism, fibrinolysinemia, fibrinogenopenia, disseminated intravascular clotting and thromboplastin complication. These alternate terms fail to describe the exact hematologic condition. Rarely, fibrinolysin can be shown to be increased, and then only very early. Depletion in fibrinogen due to intravascular clotting resulting from the thromboplastic action of tissue juices, decidual extracts or amniotic-fluid is the most common cause of defibrination. Such thromboplastic action converts prothrombin to thrombin, which, in turn, causes fibrinogen to be converted to fibrin. Fibrin is an insoluble gel. In the circulating blood, it leads to disseminated embolization with occlusions of the terminal arterial radicles of the capillary bed. Such fibrin deposits exist only with sudden death and are not found if the mother survives for a period after the acute episode. Lysis of these occurs during the period of survival. Determination of the plasma fibrinogen depression reflects the extent of the defibrination process.

Schneider [39] suggests that thromboplastin can enter the circulation only if it is fed by an arterial supply. Blood or amniotic-fluid when mixed with fetal catabolites, juices or decidual extracts enter the circulation by a hydraulic pump action into the maternal villous lake through a retroplacental hematoma in abruptio placentae, or in the passage of amniotic-fluid between the membranes and the decidua. Because of the low thromboplastic action of amniotic-fluid, Reid [33] and Weiner [44] have suggested the term "amniotic-fluid infusion" as more descriptive of amniotic-fluid embolism. Certainly, in the dead-fetus syndrome, infusion more accurately describes the chronic absorption of amniotic-fluid, rich in fetal catabolites, as the defibrinating influence.

Hodgkinson,[10] using the Wu-Ling assay method has been able to follow the clinical course of defibrination. The lower limit of normals for fibrinogen is 220.† Between 220 and 150.† fibrinogen is depressed but without recognizable clinical symptoms and justifies the designation "subclinical" defibrination. Between 150 and 90,† fibrinogen depletion is accompanied by symptoms characteristic of

*Presented at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 19, 1958, Section on Obstetrics and Gynecology. This work is from the University of Pennsylvania.

†Milligrams per 100 cubic centimeters of plasma.

the "clinical" disease. Under 90,† complete failure of the coagulation mechanism becomes evident. With reference to clinical terminology Hodgkinson [10] further suggests "hyperacute" as applied to the usual fatal type associated with amniotic-fluid embolism. The term "acute" is applied to the abruptio placentae syndrome while "chronic" is applied to the dead-fetus syndrome. Although the recovery rate is slower in the dead-fetus syndrome it cannot be relied upon to determine the dosage of either blood or fibrinogen in the treatment of coagulation defects.

ABRUPTIO PLACENTAE

Thrombocytopenia, deficiency in prothrombin or Ac-globulin may be associated with abruptio placentae, but in the main, lowered fibrinogen levels will be the cause of the defect. Treatment is directed along these lines for correction before a definitive method of termination can be decided. Too hasty decisions for vaginal or abdominal delivery will simply increase the hazard to the already acutely ill patient.

The most severe acute disorders of defibrination in abruptio placentae, if not immediately lethal in a single bout can be self-limiting and can be treated with adequate supportive therapy. If permitted to progress, renewed bouts will result from the intense contractions and the myometrial damage of uterine apoplexy. The increase in defibrination demands specific as well as supportive therapy. Specific therapy would include treatment of the defibrination [34] and termination by prompt delivery.[39] The timing and method of delivery should not be settled until proper coagulation studies have been done. The above-listed causal defects should be determined. However, depleted fibrinogen levels will be the most common. Frequently, time is important and fibrinogen determinations too slow for practical purposes. Observation by the clot stability test is available in any hospital. Unanticoagulated venous blood is incubated at 37 degrees Centigrade for one hour and observed for stability and is directly related to the defibrination by the depressed fibrinogen and not its etiology. Lysis may occur over a longer period and continued observation for more than one hour is helpful. A second rapid test, Fibrindex, employs the addition of purified human thrombin to the serum of the patient. The rate at which the clot is produced is proportional to the amount of fibrinogen available. Such unstable clots are deficient in fibrin and fibrinogen should be given along with replacement of blood loss before the pregnancy is terminated.

Abruptio placentae may begin as a small retroplacental hematoma but with the onset of labor complete separation of the placenta in renewed bouts increases the defibrination by increasing the thromboplastic activity. If the induction of labor is valid, will it increase the defibrination? The decision rests on whether the condition of the cervix will insure rapid delivery. If the cervix is "ripe," that is, dilating or dilatable to accomplish the delivery in an hour or two, rupture of the membranes and the administration of oxytocin injection (USP)* may be the procedure of choice. It has been shown [25] that USP oxytocin injection* has no effect on blood coagulation. If, on the other hand, the cervix is long and closed with the presenting part at a high station, cesarean section would be the wiser choice. The general condition of the patient, the estimated blood loss and the amount of defibrination determines the ante-partum treatment. If whole blood is used to replace blood loss it should be fresh and given in adequate amounts. Each 500 cubic centimeters will contain about 0.5 milligrams of fibrinogen. Such replacement may be self-limiting for the process. Fibrinogen levels under 90† will require at least 4 Grams of fibrinogen which may be obtained through the Red Cross free but is commercially available as Parenogen® (Cutter). If stored, oxalated blood is used. Ac-globulin may be depleted but can be combated with fresh frozen plasma. Following delivery, continued determinations of fibrinogen should be made and treated accordingly until bleeding is controlled.

At cesarean section when bleeding continues in association with a Couvelare uterus the

*Used under the Parke, Davis registered tradename of Pitocin.

doctor is frequently tempted to combine hysterectomy with the section, in order to control hemorrhage. If the uterus contracts well and bleeding continues, such a procedure serves only to transfer the bleeding points from the uterus to the cervical stump or vagina where it cannot be controlled. Continued treatment of the defibrination is advised rather than additional surgery.

A 20 year-old gravida 3, para 2, was admitted with a history of profuse vaginal bleeding and abdominal pain. Physical examination showed conclusive evidence of abruptio placenta. Blood pressure was 94/74 and her hemoglobin was 9.5 Grams. The fetal heart tones were 95 and vaginal examination showed the cervix at one centimeter with the vertex at -2 station. History revealed that the first pregnancy in 1951 was terminated by cesarean section for a bleeding indication and that the fetus was lost ante-partum. In 1955 the second pregnancy terminated in vaginal delivery of a living child.

A simple clot stability test showed a firm clot in 7 minutes and preparations for cesarean section were carried out while transfusion was begun. A Munro-Keer cesarean section was done with the delivery of a 1440 Gram male child who survived. Estimated blood loss at delivery was 500 cubic centimeters. As she was being transferred to a litter the blood beneath the buttocks was noted to be free of clots. The diagnosis of hypofibrinogenemia was made and fibrinogen secured. Post-partum, she received 1850 cubic centimeters of whole blood, 6.5 Grams of fibrinogen plus 160 cubic centimeters of fresh frozen plasma. Complete coagulation studies were carried out after she had received blood and some fibrinogen and revealed only poor clot retraction. At that time there was no defibrination and no fibrinolysins could be demonstrated. Except for oliguria 24 hours post-partum she made an uneventful recovery and both mother and child were discharged in good condition.

DEAD-FETUS SYNDROME

The dead-fetus syndrome presents a different type of defibrination problem because of its chronicity. In the early studies of coagulation defects it was believed that the Rh-sensitized mother was more likely to have the problem. Recent investigations by Schneider,[39] Jackson,[13] Hodgkinson[10] and others have shown the Rh-isoimmunization is important only in that intrauterine fetal-death is more common in this situation.

The retention of the dead-fetus, according to Schneider,[39] represents a hemipregnancy. Portions of the placenta and fetus undergo autolysis and necrosis and autoextraction of tissue juices occurs through the viable portion of the placenta which still has an arterial blood supply. Direct evidence of widespread initiation of coagulation, namely, fibrin deposition, has not yet been found in the dead-fetus syndrome, even with coexisting abruptio placentae, but has been found in an anatomically comparable condition, that of hydatidiform mole.

The retention of a dead-fetus is not necessarily associated with the development of a coagulation defect, even when the dead-fetus is retained for a prolonged period. The possible development of defibrination should be realized in retention of a dead-fetus, and appropriate tests performed to detect such an abnormality. In Jackson's[13] study of this problem, hypofibrinogenopenia, thrombocytopenia, hypoprothrombinopenia, and reduction on the Ac-globulin were found. Again the depletion of fibrinogen is the most likely mechanism for the production of this defect.

When the diagnosis of a dead-fetus has been established, it does not necessarily alter the time honored management. However, frequent determinations of fibrinogen should be made at least weekly and the patient observed clinically for hemorrhagic diatheses such as bleeding from mucosal areas and the formation of ecchymoses. Waiting for the onset of spontaneous expulsion of the products of conception is still a good policy. Knowing the mechanism of escape of necrotic products with thromboplastic action into the maternal circulation, it is plausible that induction of labor with Pitocin® and its resultant vigorous contractions would increase the discharge of these products and further increase the defibrination. Conceivably, simple rupture of the membranes and release of its thromboplastic activity would arrest the defect in the maternal circulation. Rupture of the membranes without the prompt onset of labor presents an additional hazard of infection. Pritchard[28] studied this problem in 27 cases of prolonged retention of a dead-fetus. First of all, he found that abortion of the missed type occurring in the first trimester presented no problem unless

associated with the addition of sepsis. Twenty-seven per cent of his cases developed hypofibrinogenemia but all were confined to patients who were more than 16 weeks pregnant and had retained the dead-fetus for more than 5 weeks. To date, in 26 cases, Pritchard has studied the termination of pregnancy with and without the use of oxytocin injection, USP.* In eight patients with prolonged intrauterine retention of a dead-fetus in whom labor occurred spontaneously, including one with pre-existing hypofibrinogenopenia the concentration of fibrinogen was measured either before or very early in labor and again within 5 to 30 minutes after delivery. In eight other cases, in two of which there was hypofibrinogenopenia, labor was induced and maintained with oxytocin injections, USP;* in these cases the fibrinogen level was determined just before the oxytocic was started and again within 5 to 30 minutes after delivery. In a control group of 10 patients at or near term in whom the fetus was live, labor was induced and maintained with the oxytocic* and any change in the concentration of fibrinogen determined. The maximal changes of fibrinogen in these 26 patients ranged from an increase of 14 per cent to decrease of 14 per cent. It was therefore concluded that spontaneous or oxytocic induced labor with a dead-fetus had no deleterious effects on the circulating fibrinogen. I have carried out labor with the aid of oxytocin injection, USP.* in three additional patients whose fibrinogen was normal before induction and none showed any tendency to a coagulation defect. It would seem plausible that any pregnancy of more than 16 weeks' duration with a dead-fetus retained more than 5 weeks could and probably should have the uterus emptied by induction. In any event, the fibrinogen levels, if reduced, before delivery will return to normal within a few hours after delivery.

A 33-year old gravida 3, para 2 was admitted to the labor floor fully dilated and membranes intact. No fetal heart tones were heard. She was Type A, Rh negative with a homozygous Rh positive husband.

She had had a nephrectomy in 1940 with transfusion of untyped blood for the Rh factor. Her first pregnancy in 1948 terminated with a stillborn delivered at 36 weeks. The Rh antibody titre was 1 to 128 in albumin. The second pregnancy terminated in a similar fashion in 1951. The titre at that time was 1 to 1024 in albumin. No coagulation defects were noted.

The present pregnancy was due to terminate October 19. It was uneventful except for a rise in titre to 1 to 5096. This was reported in August following which no fetal heart tones were heard. There was radiographic evidence of fetal death two weeks later. Six days later she was admitted and delivered spontaneously a macerated 400 Gram fetus. There was a slight increase in bleeding postpartum due to poor uterine tone and was combated with oxytocics. Two hours later she was readmitted to the labor floor having lost 1500 cubic centimeters per vaginam. Ecchymoses were noted over both iliac spines and coagulation studies ordered. Transfusion had been previously begun. The simple clot test showed clotting in 9 minutes with complete lysis in 30 minutes. She received a total of 2500 cubic centimeters of blood. Fibrinogen levels were reported at 30.† It was calculated that 22 of this had been controlled and the following day the clot test showed firm clotting at 6 minutes and lysis in 2 hours. The fibrinogen level was 120.† Fibrinolysins were demonstrated in the blood.

Recovery was complete and in the intervening 5 years, she has not become pregnant.

AMNIOTIC-FLUID EMBOLISM

OBSTETRIC shock first acquired specific meaning in 1941 with the discovery of maternal pulmonary amniotic-fluid embolism by Steiner and Lushbaugh.[42] They arrived at several conclusions which they evaluated not only by correlation of clinical and autopsy findings, but also by animal experiments. The shock is due primarily to disseminated occlusion of the pulmonary arterial circulation by embolic debris, and is a kind of "anaphylactoid" shock. The embolic, pulmonary, vascular obstruction may be aggravated by vasospasm and may lead to acute dilatation of the right heart.

Steiner and Lushbaugh[42] observed that in amniotic embolism: (1) Intravascular fibrin deposition did not occur. (2) Coagulation was peculiar inasmuch as there was a clinical record of hemorrhage in most of the patients before death. Nevertheless, these authors recognized a state of true obstetric shock, distinct from shock of obstetric hemorrhage, and this interpretation was later confirmed by finding of amniotic emboli with fatal shock but without hemorrhage. The third is that de-

scribed by Reid [33] as a sequelae of embolism in which intravascular clotting occurs with resulting hypofibrinogenemia. The findings were insufficient to have caused death as such but they exhibited hemorrhagic manifestations and ultimately died of post-partum hemorrhage.

The predisposing factors which result in amniotic-fluid embolism are: tetanic uterine contractions, meconium in amniotic-fluid, advanced maternal age, large baby, multiparity, difficult operative delivery and the presence of a dead-fetus. Although amniotic-fluid is relatively low in thromboplastin content, fragmentary knowledge suggests that probably augmented thromboplastin concentration in amniotic-fluid results from the above prevailing circumstances. The autoextraction of this may be comparable to that seen in abruptio placentae except that blood is not the medium.

The symptoms of amniotic-fluid embolism are those of dyspnea, shock and cardiopulmonary insufficiency. Many pathologists find it difficult from postmortem findings in the lungs to correlate these minimal changes with the cause of death. With this justification there has been some hesitancy in accepting the syndrome of amniotic-fluid embolism as a definitive entity. It is difficult to conceive that death of an anaphylactoid nature could occur during the physiologic process of reproduction. The diagnosis of amniotic-fluid embolism is rather frequently made when sudden obstetric death occurs. In such circumstances faulty anesthesia or cardiac failure has been shown on more than one occasion to have been the cause of death.

Reid [33] believes that amniotic-fluid embolism exists as a rare entity and can be responsible for death in the intra-partum period and cautions for a more careful search of the lungs at autopsy for the presence of the debris. If the patient survives the initial shock and develops the "hyperacute" clinical defibrination, death will result from post-partum hemorrhage.

A careful search of our own records has failed to reveal a single case of death due to amniotic-fluid embolism. In cases of sudden death the typical findings have been searched for without result.

SUMMARY

1. A plea is offered for a more complete search pathologically for confirmation of amniotic-fluid embolism rather than offering it as a clinical diagnosis unless all other responsible factors are eliminated.

2. When abruptio placentae is diagnosed, delay in the termination of the pregnancy will permit a more thorough study for possible coagulation defects. If found, treatment preoperatively by replacement of blood loss and administration of fibrinogen to correct the coagulation defect will be given before labor is induced or cesarean section attempted. Cesarean hysterectomy should be done only when the bleeding is due to failure of the uterus to contract and not to defibrination. Continuation of treatment after operation by blood and fibrinogen if indicated by follow-up studies.

3. Retention of a dead-fetus should *not* be treated by masterful inactivity. Careful study of blood coagulation weekly and close clinical observation will aid in timing the termination of pregnancy. Further, pregnancy of 16 weeks or longer, and retention longer than 5 weeks can be safely terminated by induction.

4. A maternity department should have at least 4 Grams of fibrinogen available at all times to combat these emergencies.

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A bibliography of 45 listings appears in Dr. McElroy's reprints.

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Massive Intraperitoneal Hemorrhage Due to Paracentesis

An apparently "routine" paracentesis can lead to intra-abdominal hemorrhage, particularly in the presence of portal hypertension. An omental varix, in this case, was punctured by the paracentesis needle.

A case is presented below of a complication of "routine" paracentesis with massive intraperitoneal hemorrhage.

A sixty-five-year old woman was readmitted to the medical service of The Mountainside Hospital, complaining of anorexia, shortness of breath, diarrhea, and abdominal distention of three weeks' duration. Her cardiac condition was known to be Class 4-C. Four months prior to the present admission a mitral commissurotomy had been attempted but was found to be contraindicated because of the degree of mitral insufficiency. Postoperatively, she was placed on a cardiac regimen, and followed by her local physician. She developed the present complaint during this time, and became refractory to medication. The present admission was for re-evaluation.

The past history included rheumatic fever at age eight salpingectomy for probable pyosalpinx at 35, uterine suspension and appendectomy a number of years previously, simple mastectomy for benign lesion at 46, and cholecystectomy at 53. None of this surgery was at Mountainside Hospital. The patient was thin, pale, and alert. There was marked cervical vein engorgement, with bilateral basilar râles, ascites, and peripheral edema. The abdomen, which was greatly distended, presented surgical scars in all quadrants except the left lower. Tenderness was more marked in the right lower quadrant. There was shifting dullness with the presence of a fluid wave. The liver and spleen were palpable. Pelvic examination revealed a moderate cystorectocele, and great tenderness in the right fornix. No specific mass was noted. Fullness and tenderness were marked in the pouch of Douglas.

The patient was dyspneic, respiration 28; pulse 60, irregular, and of good quality; blood pressure 130/70; and temperature normal. The hemoglobin on admission was 9.2 Grams and the hematocrit 35 per cent.

The impression on admission was: (a) Rheumatic heart disease with auricular fibrillation, mitral stenosis and insufficiency; (b) Congestive heart failure; and (c) the likelihood of digitalis intoxication and pelvic pathology.

On the day of admission, we did a diagnostic abdominal tap to determine the nature of the ascitic fluid. A number 18 gauge needle was introduced into the left lower quadrant at a point 5 centimeters below the umbilicus in the anterior axillary line. This was the only area free of operative scars and palpable organs. No fluid was obtained on penetration of the peritoneal space. Bleeding at the site of the skin puncture was greater than normally encountered. It was easily stopped by the application of a butterfly bandage.

One hour after this procedure the patient appeared to be apprehensive. Her skin was pale, cold, and clammy. The pulse was 100, irregular and weak. Blood pressure was 86/50. The degree of abdominal distention was unchanged. Bowel sounds were present. The only new finding was tenderness at the site of paracentesis, but to the degree expected. Possible perforation of an aberrant blood vessel or spleen was suspected. The shock-like picture could also have been the result of persistent watery diarrhea since admission. Antihemorrhagic agents, antibiotics, and 500 cubic centimeters of

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whole blood were administered. A flat plate of the abdomen at this time was unremarkable. Laboratory examinations showed a hemoglobin of 7.4 Grams, leucocyte count of 17,200 with a shift to the left. Additional laboratory examinations showed no essential change during the next 12 hours. A second transfusion (500 cubic centimeters) of whole blood was given through the night.

On the next morning she appeared improved, with the vital signs normal. Abdominal distention had increased somewhat and the bowel sounds were hypoactive. The predominating area of tenderness was limited to the paracentesis site. The flat plate of the abdomen 36 hours after the paracentesis showed gastric distention, gas in the large bowel, and an area of increased cloudy density in the right lower quadrant. Intestinal intubation relieved the gastric distention.

On the next day (48 hours after paracentesis) the abdomen was very tense, with generalized rebound. Her general condition had deteriorated. An exploratory laparotomy was decided upon. The danger of the "acute abdomen" which had not responded to conservative management, was believed to out-weigh the danger of an extremely poor surgical risk. Accordingly an exploratory laparotomy was done under spinal anesthesia. Approximately 6 liters of hemo-ascitic fluid were aspirated from the peritoneal cavity. A large accumulation of blood clots (limited chiefly to the pouch of Douglas and the area of the previous uterine suspension) was also removed. The greater omentum was markedly thickened with multiple adhesions and large tortuous varices. Beneath the site of paracentesis was an area of a firm fibrinous clot measuring 3 by 6 by 10 centimeters. This surrounded a dilated omental varix. There was no active bleeding at this time. No other procedure was done, except for the removal of the fluid and loose clots, since hemostasis was present. No other surgical conditions were detected. The postoperative course was uncomplicated. Two weeks following surgery the patient was discharged to the care of her local physician.

The possible pathologic physiology in this case is as follows: The patient had advanced rheumatic heart disease with decompensation and gastro-intestinal symptoms prior to admission. The latter probably resulted from a combination of digitalis overdosage and the sequelae of portal hypertension. The intense peritoneal hemorrhage was the result of perforation of an omental varix caused by portal hypertension. The varix was adherent to the peritoneum due to previous surgery.

It is believed that the bleeding had stopped 6 to 8 hours after the diagnostic peritoneal tap, as substantiated by the stability of the hematocrit and hemoglobin following the initial drop. Possible hepatic dysfunction secondary to congestive failure may also have played a role in the hemorrhage. Therefore the antihemorrhagic drugs may have helped establish hemostasis. The subsequent signs and symptoms of an acute "surgical abdomen" were probably the result of the intraperitoneal hemorrhage causing peritoneal irritation, increasing abdominal distention, traction on previous surgical adhesions, and the localization of clots in the pelvic floor.

ONLY five case reports of intraperitoneal hemorrhage following diagnostic or therapeutic puncture of the abdominal wall have been found in the literature. At least three ended in fatality.[1,2,3] One of these, cited by Marshall,[2] was a case of bleeding following liver biopsy. Another one, reported by Macdonald,[3] was a case of hemorrhage following paracentesis abdominis. The outcome of the fourth case[4] is not known to the authors because of translation† difficulties. In the fifth case hemorrhage was due to laceration of the cystic artery during biopsy of the liver. As a result of prompt surgical intervention this patient recovered.[5]

Macdonald's case[3] is that of a 58-year old man with recurrent ascites for four years in whom large amounts of fluid had been withdrawn from the abdominal cavity during this period. In the performance of the patient's last paracentesis, 5,400 cubic centimeters of bloody fluid were aspirated. A few hours later he was found lying on the floor beside his bed. He remained in shock until he died. At necropsy, there was no laceration, perforation or rupture of any internal structure. Macdonald[3] thought the needle may have damaged the collateral veins of the abdominal wall, or that fibrinogenopenia may have been present.

†The report was in Russian.

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5. Kaplan, A. A., Frobese, A., and Bockus, H. L.: Gastroenterol., 37:227 (Aug., 1954).

Another case of intraperitoneal hemorrhage was the result of rupture of an aneurysm of the right common iliac artery occurring in an 11-year old girl. The case was reported by Fernbach *et al.*[6] The only resemblance this case bears to the one here reported is a history of two episodes of acute rheumatic fever with aortic and mitral valvulitis. Fernbach [6] thinks that the aneurysm was mycotic, secondary to subacute bacterial endocarditis. Biopsy of the wall did not give definite proof of this supposition.

SUMMARY

A CASE has been reported of intraperitoneal hemorrhage occurring after abdominal paracentesis performed for ascites on a patient with cardiac decompensation. Surgical exploration showed that the paracentesis needle had punctured an omental varix. Recovery was uneventful, after removal of the clots and subsequent management. It is suggested that the possibility of intra-abdominal bleeding be considered to be one of the causes of shock following paracentesis in cases of portal hypertension and ascites. This is in addition to the widely-held concept of the shock like syndrome following the aspiration af a large quantity of abdominal fluid.

In conclusion the complication of intraperitoneal hemorrhage as the result of paracentesis is potentiated in the presence of portal hypertension and post-operative adhesion.

6. Fernbach, P. A., Berman, L., and Cohen, B.: Annals of Surgery, 135:570 (April, 1952).

The Mountainside Hospital, Montclair, New Jersey

Smoking Affects Births

Premature births are significantly greater among mothers who smoke than among non-smoking mothers, according to Dr. Winea Simpson.*

Dr. Simpson bases her report on data collected from 7500 patients. She finds the number of premature births to be twice as great for mothers who smoke as for non-smoking mothers. The prematurity rate at private hospitals increases with the number of cigarettes smoked per day. The highest prematurity rates were for heavy smokers and the lowest for non-smokers. In the public hospital, with undernourished, overworked patients, the prematurity rate for non-smokers is relatively higher than for the private hospitals and there is less difference between the prematurity rate for smokers and non-smokers.

*Simpson, Winea: American Journal of Obstetrics and Gynecology 73:808 (April 1957)

Cervical Cancer Tests

Routine "smear" examinations for cervical cancer may not be needed any oftener than every two years, a Wisconsin study suggests. If a woman shows no signs of cancer after a cervical smear test and a thorough physical examination, she probably will remain free of cancer for at least two years. The study, covering 15,389 women, was reported by Beverly Schulz, B.S., Dr. David J. Carlson and Dr. Edward A. Birge of the Milwaukee Hospital. —J.A.M.A., September 20, 1958.

Samuel A. Goldberg, M.D.

Newark

Cancer of the Large Bowel*

Fourth of a series prepared by the Cancer Control Committee of The Medical Society of New Jersey.

Carcinomata of the cecum, colon and rectum are among the more common lesions of the body accounting for about 8 per cent of all cancers. Males and females are about equally affected. Although it may occur at any age it is usually seen after the age of forty. It is most common in the sixth and seventh decades of life.

Most, if not all, carcinomas of the large bowel arise from adenomatous polyps. About 2 per cent of cases are preceded by chronic ulcerative colitis. They are distributed as follows: (Busar) Distal to recto-sigmoid 57.7 per cent, sigmoid 13.6 per cent, descending colon 9.4 per cent, cecum 6.9 per cent, ascending colon 4.6 per cent, transverse colon 3.8 per cent, hepatic flexure 3.2 per cent, splenic flexure 1.7 per cent. In 7.5 per cent the lesions are multiple.

The tumors may be of the type which fungate, ulcerate and diffusely infiltrate. Fungating growths are sessile, protrude into the lumen in a cauliflower-like fashion and may be superficially ulcerated. Ulcerating tumors penetrate the wall early. Infiltrating growths permeate the wall of the gut circumferentially and over varying distances longitudinally. The mucosa may remain intact or may ulcerate. They may result in ring-like constrictions, referred to as napkin ring-like tumors.

Histologically carcinoma of the colon or rectum is almost always an adenocarcinoma with various cellular types of differentiation. They may show mucinous degeneration. Anaplastic type of cells and signet-ring type of cells in single file extending into the muscle coats may also occur, similar to those seen in *linitis plastica* in the stomach. Argentaffin carcinoma is more likely to affect the cecum than the colon. It is much slower in producing symptoms than other types of carcinoma.

Isolated polyps of the large bowel occur in 2 to 8 per cent of the general population. They may be single, but more often are multiple. They may occur throughout the entire length of the colon but are more numerous in the rectosigmoid hence most are within reach of the sigmoidoscope. Polyps may be pedunculated with a small, soft red raspberry-like head and a long slender flexible stalk, or they may be sessile warty excrescences which sit directly upon the colonic mucosa without a demonstrable stalk. They vary between 2 and 3 centimeters in diameter and may occasionally reach a diameter of 10 centimeters. They have a soft red cauliflower appearance. The exposed tips of these polyps may show hemorrhagic necrosis, ulceration or sloughing.

Histologically, they vary from well differentiated normal colonic mucosa to markedly atypical thick mucosa composed of branching, distorted glands separated by scant connective tissue. From this relatively benign group all stages of hyperplasia and atypicality are

*This work is from the Presbyterian Hospital in Newark, a unit of the United Hospitals of Newark.

encountered to lesions that verge on frank malignancy. Congenital familial multiple polyposis is an uncommon disease in which the mucosa of the large bowel is entirely covered by numerous small, usually pedunculated polyps.

Squamous cell carcinoma and melanocarcinoma occur primarily in the anal region and may extend upwards into the rectum.

Benign lymphomas are common. They usually occur in the anorectal region. Malignant lymphomas in the large intestine are being reported more frequently than previously. Males are more often affected than females. They occur more commonly between the ages of 20 and 50. One-third of the lymphomas are seen in the rectum and about two-thirds in the cecum. Large fungating masses with ulceration are present in about 25 per cent. Benign tumors, particularly of the cecum may produce intussusception. Leiomyoma or leiomyosarcoma are infrequently seen in the large intestine.

Diagnosis: A palpable mass in the left or right colon should be considered malignant until proved otherwise. Many rectal neoplasms can be reached by digital examination. Others, below the rectosigmoid, may be visualized by a sigmoidoscope. X-ray examination by barium enema reveal those higher up.

Occult blood in the stool or anemia should make one suspicious of an enteric neoplasm.

A Papanicolaou smear from a lesion may reveal neoplastic cells.

Differential diagnosis: Chronic diverticulitis may simulate a neoplasm clinically and roentgenologically.

27 South Ninth Street

Beware That Chocolate

Milk chocolate in solid or liquid form appears to be the leading offender in the production of tooth decay, reports William W. Mueller,* University of Massachusetts.

Cocoa powders or chocolate syrups added to milk definitely inhibit the growth of bacteria likely to be found in milk, with the exception of Streptococcus lactis. Furthermore, it was concluded from studies with pure tannic acid that the tannic substances of the cacao products are the agents responsible for inhibiting bacterial growth.

Dr. Mueller explained that bacteria in tan liquors are largely acid-producing organisms and that Streptococcus lactis is the chief producer of lactic acid. "Any inhibition of non-acid producing micro-organisms by tannin-like substances should increase the growth of acid producers because of lack of competition," he said.

Other investigators have found that the inhibition of bacterial growth is greater at room temperature than at refrigerator temperature, he added. "Therefore, one would expect a still greater inhibition at mouth temperature with a further increase in acid production."

*Caries-producing potential of chocolate, J.A.M.A. 168:436 (Sept. 27) 1958.

Polyps and Cancer

Early detection of polyps in the large intestine can help reduce deaths from intestinal cancer. Once detected they can be removed surgically, reports J. Maurice Robinson.*

The problem of reducing the mortality of cancer of the large bowel and rectum, now responsible for 17 per cent of all deaths from cancer, is closely linked to the detection and eradication of the polyp, which is apparently the precursor of the malignancy.

*Robinson, J. M.: Polyps of the Colon: How to Find Them. American Journal of Roentgenology, Radium Therapy and Nuclear Medicine, 77:709 (April) 1957.

Otto Brandman, M.D., *et al.*

Maplewood

Blood Levels and Urinary Excretion of a Long-Acting Sulfonamide*

Here is a pioneer presentation on the effectiveness of a new sulfonamide, which produces high blood levels of long duration.

Madribon® is a new, potent sulfonamide that produces high blood and tissue levels of long duration in rats and has high antibacterial action.[1,2,3] This initial study indicates the prolonged blood levels and the slow excretion of Madribon® in human subjects. The sulfonamide administered in single or multiple doses produces blood levels similar in duration of those observed with sulfamethoxypyridazine.[4] The drug is 2,4-dimethoxy-6-sulfanilamido-1,3-diazine.

The first part of this paper summarizes the blood level and urinary excretion data obtained following a single oral dose in human subjects. The experiment, devised by Dr. Leo Pirk, was carried out by Drs. Brandman and Oyer.

Seven patients were given a single Gram dose of Madribon® and blood and urine specimens were collected over four and five days. On the sixth day, a 2 Gram dose was given to the same subjects and again blood and urine specimens were collected over four and five days. On the 12th day, a 4 Gram dose was given to six of the seven patients and blood and urine specimens collected over four and five days.

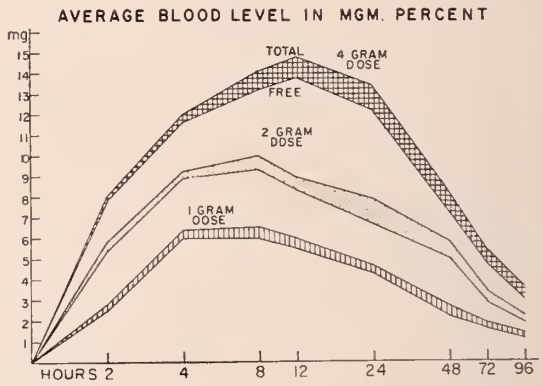


Figure 1. Average human blood levels after oral administration of single doses of 1, 2 and 4 Grams of Madribon®.

Free and total sulfonamides were determined by the Bratton and Marshall method.[5] The standard curve was prepared by adding known amounts of Madribon® to blood and urine and then measuring the color development by the usual procedure.

The results in Figure 1 illustrate the average blood level values obtained. Peak sulfonamide levels were reached in about four hours after 1 Gram, eight hours after 2 Grams and twelve hours after 4 Grams. The calculated half-life is 34, 36 and 38 hours at the respective dose levels. Measurable amounts are still present after 96 hours. The amount of es-

*Co-authors of this work include Dr. Calvin Oyer and Dr. Recha Engleberg. This is from St. Michael's Hospital in Newark in cooperation with the Pharmacology Department of Hoffmann-La Roche in Nutley.

1. Semenitz, E.: Zeitschrift fur Immunitatsforschung, 111:388 (1954).

2. Schnitzer, R. J. *et al.*: In press.

3. Randall, L. O. *et al.*: In press.

4. Jones, W. F. and Finland, M.: Annals of the New York Academy of Science, 69:473 (1957).

5. Bratton, A. C. and Marshall, E. K.: Biological Chemistry, 128:537 (1939).

terified sulfonamide averages about 10 per cent for the three dose levels over the period studied.

Average amounts of sulfonamide found in the urine after oral administration of doses of 1, 2 and 4 Grams are plotted in Figure 2. In 120 hours, 80 per cent of the 1 Gram dose was recovered, of which 24 per cent was esterified. Sixty-seven per cent of the 2 Gram dose was recovered during the same interval and 16 per cent was esterified. Fifty-seven per cent of the 4 Gram dose was recovered while 16 per cent was esterified.

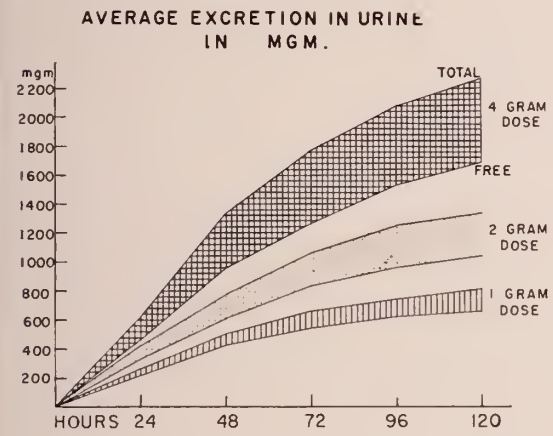


Figure 2. Urinary excretion (human subjects) after oral administration of single 1, 2 and 4 Gram doses of Madribon®.

In the second series of experiments, Madribon® was administered orally to six subjects in doses of 2 Grams the first day followed by 1 Gram for five successive days. Blood samples were taken 24 hours after each dose and 24 hour urine collections were made. In the second experiment, five of the same six subjects were given 2 Grams of Madribon® each day on six successive days. In the third experiment, two of the same subjects received 2 Grams on the first day and 1.5 Grams for five successive days. Blood and urine samples were collected as above.

Average blood levels are plotted in Figure 3.

In the first experiment, the free sulfonamide in the blood was approximately 7 milligrams per cent when measured 24 hours after the first 2 Gram dose. The level was maintained on a plateau when 1 Gram was given on each successive day.

In the second experiment, the initial dose of 2 Grams raised the blood level to the same degree in the first 24 hours as in the first experiment, but successive daily 2 Gram doses raised the blood levels gradually to about 12 milligrams per cent by the fourth day. A plateau was then maintained at this level.

The average amounts of sulfonamide ex-

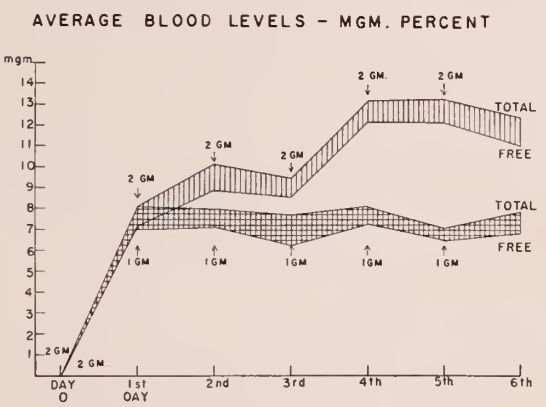


Figure 3. Madribon® blood levels (human subjects) after oral administration of 2 Grams followed by 1 Gram per day for 4 days and after 2 Grams per day for 5 days.

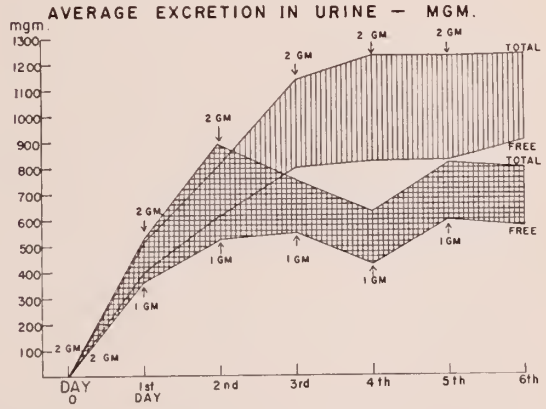


Figure 4. Madribon® levels in human subjects after initial oral administration of 2 Grams followed by 1 Gram a day for 4 days or administration of 2 Grams a day for 5 days.

creted in the urine are given in Figure 4. In the first experiment, on the dosage schedule of 2 Grams the first day and 1 Gram on successive days, the urinary excretion of sulfonamide was maintained at about 0.8 Grams per day. About 80 per cent of the drug was therefore excreted daily on a constant drug intake of 1 Gram.

In the second experiment, the daily dosage

schedule of 2 Grams, resulted in a urinary excretion of about 1.2 Grams daily by the fifth day or about 60 per cent of the daily dose was excreted during each 24-hour period.

In the third experiment, the dose schedule of 2 Grams initially followed by 1.5 Grams daily resulted in the urinary excretion of about 0.95 Grams per day. This represents about 60 per cent of the daily administered dose.

SUMMARY

1. The oral administration of Madribon® to human subjects produced peak blood levels within 4 to 12 hours depending on the size of the dose. The half-life ranged from 34 to 38 hours. The excretion in the urine was also prolonged. About 80 per cent of a single 1 Gram dose was recovered but only 57 per cent of a 4 Gram dose was excreted. From 16 to 24 per cent was eliminated in the esterified form.

2. A dose schedule of 2 Grams initially followed by 1 Gram per day induced a blood level of about 7.0 milligrams per cent and a urinary excretion of 0.8 Grams per day.

3. A dose schedule of 2 Grams daily induced a blood level of about 12 milligrams per cent and a urinary excretion of about 1.2 Grams per day.

558 Prospect Street

A Disappearing Scar?

Writing in the January 1957 issue of *Northwest Medicine*, V. K. Hillman points out that the postoperative scar is the only visible evidence of the surgeon's skill that the patient can see and compare—and scars are often compared. While plastic surgeons have long known how to leave a good scar, most general surgeons are so interested in the underlying disease that they overlook the benefits of making and closing incisions according to principles of plastic surgery.

These are: (1) gentle handling of tissues, and (2) observance of natural wrinkle lines. The first category includes tying of sutures too tightly, both in the skin and other locations. To avoid wrinkles caused by skin sutures use more sutures with less tension on each; *subcuticular sutures obviate the problem entirely.*

The natural elasticity and free movability of the skin make the placement of incisions in natural wrinkle lines easy. Habitually, incisions for common operations are made in exactly the same plane as the intended incision in the underlying fascia. Yet a transverse incision can be retracted to accommodate even a vertical fascial incision, as in the Pfannenstiel and collar incisions.

For example, instead of a McBurney incision, a transverse incision can be made, the internal oblique split and retracted, and exposure is as satisfactory as in the McBurney method. For any necessary enlargement, both rectus muscles may be severed and still leave a straight line scar that tends to disappear.

Similar utilization of natural wrinkle lines results in disappearing scars after herniorrhaphy, hysterectomy, breast biopsies and cholecystectomy.

Henry Green, M.D.

Newark

A Fluoroscopic Sign of Pulmonic Stenosis*

When it is present, asymmetric pulsation of the branches of the pulmonary artery represents a reliable roentgenologic sign of valvular pulmonic stenosis. In general, fluoroscopy is a valuable tool in the diagnosis of this type of stenosis.

The usual roentgenologic aspects of uncomplicated valvular pulmonic stenosis without over-riding of the aorta have been repeatedly described. In 1918, Vaquez and Bordet [1] emphasized three cardinal manifestations of pure pulmonic stenosis: (1) a prominent right auricle and ventricle, (2) a normal left auricle and ventricle, and (3) a prominent pulmonary artery shadow—presumably due to post-stenotic dilatation of the pulmonary artery. These criteria have been largely substantiated, and occasionally elaborated, by a number of observers. Dow and co-workers [2] agreed with these findings, particularly the second and third noted above, and added that intrapulmonary vascular markings were frequently normal. They indicated, interestingly enough that in no instance, in a series of eight cases, was a hilar dance seen. Anatomically, they found that the post-stenotic dilatation did not extend beyond the bifurcation of the pulmonary artery. Engle and Taussig [3] stated that pulsations in the pulmonary artery were minimal to absent. Galligan and his co-workers [4] observed that the typical roentgen findings in congenital pulmonic stenosis were (1) right ventricular hypertrophy, (2) disproportionate enlargement of the main pulmonary artery segment and the left root shadow as compared to the right root shadow, while (3) the peripheral vascular markings were normal to diminished in prominence. Blount *et al.*,[5] said that fluoroscopic examination in pulmonic stenosis was of maximum importance. They described (a) normal lung fields in 9 of 23 patients, while the remaining 14 patients exhibited diminished vascularity of the lung fields; (b) a dilated actively pulsing main pulmonary artery was always seen; while (c) a normal right and left pulmonary artery shadow was seen in 16 of 23 patients. Decreased prominence of these vessels was noted in five instances, and increased prominence was visualized in only two patients. The authors reported diminished amplitude of the right and left pulmonary arteries in all cases—indicating that the increased pulsation of the main pulmonary artery in association with the diminished pulsations of the branch vessels was to be considered a cardinal sign of pulmonic steno-

*Presented before the Section on Chest Diseases—192nd Annual Meeting of The Medical Society of New Jersey, May 21, 1958.

1. Vaquez, H. and Bordet, E.: Quoted by Dow *et al.* in 2 below. Le Couer et L'Aorte. Etudes de Radiologie Clinique, ed 2. Paris, J. B. Bailliere et Fils (1918).

2. Dow, J. W.: Uncomplicated Pulmonic Stenosis. *Circulation*, 1:267 (Feb. 1950).

3. Engle, M. A. and Taussig, H. B.: Valvular Pulmonic Stenosis. Circulation, 2:481 (Oct. 1950).

4. Galligan, J. J., Adams, F. H. and Jorgens, J.: Congenital Pulmonic Stenosis. Journal of Pediatrics, 41:562 (Nov. 1952).

5. Blount, Jr., S. G., McCord, M. C., Kowesu, S. and Lanier, R. R.: Roentgen Aspects of Pulmonic Stenosis. *Radiology*, 62:337 (March 1954).

sis. In 1954, Sobin and co-authors [6] discussed the roentgen findings in pulmonary valvular stenosis. They quote a personal communication from H. A. Humphrey that there is (1) a constant, but variable in degree, enlargement of the right ventricle, (2) often enlargement of the right atrium, (3) dilatation of the main pulmonary artery with dilatation of the left pulmonary artery and a normal or underdeveloped right pulmonary artery, while (4) fluoroscopy demonstrated normal pulsation of the main and left pulmonary arteries in the presence of diminished right pulmonary arterial pulsing. Curiously, they do not at all particularize the latter fluoroscopic evidence in their group of 28 cases; nor do they comment on the limits of normal pulsations in the branches of the pulmonary arteries. Finally, Brewer and Brandenburg [7] assert a broad roentgen spectrum ranging from a normal appearance of the cardiac silhouette to an appearance suggestive of a left hilar mass. Between these extremes the appearance of the left hilus presented, according to these authors, a rather characteristic pattern. They indicated that this left hilar pattern associated with a normal transverse cardiac diameter and an increase in left hilar pulsation should put pulmonic stenosis first on the roentgenologist's list of diagnostic possibilities.

It is toward this varying fluoroscopic observation of the behavior of the main pulmonary artery and its branches that we direct attention.

THIRTY-SIX cases of valvular pulmonic stenosis without over-riding of the aorta, gleaned from a larger group of patients with congenital heart disease, were observed at St. Michael's Hospital, Newark, N. J., from 1952 to 1956. The diagnosis of pulmonic stenosis was established in each instance by cardiac catheterization with the demonstration of a pressure gradient of abrupt occurrence between the main pulmonary artery and the right ventricle.

In seven patients, there was a distinctly observable expansile pulsation of the left pulmonary artery, while the right pulmonary artery shadow was remarkably quiet. This finding of asymmetric hilar pulsation was always accompanied by an unduly prominent pulsation of the main pulmonary artery. These findings were always satisfactorily demonstrable to the fluoroscopist and the clinic group examining the patient. An effort was then made to determine whether this ratio (7 out of 36 or 19 per cent) was constant or merely a reflection of the observer's awareness. Accordingly, in examining patients with congenital heart disease, this fluoroscopic sign was sought. In 15 consecutive cases of valvular pulmonic stenosis without over-riding of the aorta established by means of cardiac catheterization from 1956 through March 1958, ten instances of asymmetric hilar pulsation were seen. This frequency of 67 per cent is closer to the actual frequency of this finding than the earlier frequency of 12 per cent and reflects the increasing familiarity of the clinic staff with this fluoroscopic criterion.

At this point it is of interest to pause and consider the occurrence of an actively pulsing left hilum in the presence of a quiet right hilum in conditions other than valvular pulmonic stenosis without over-riding of the aorta. I have seen this occurrence only in the absence of the right pulmonary artery on a congenital basis. This finding is also to be expected in a localized aneurysm of the left pulmonary artery, but, this pathology has, as yet, not been observed at the St. Michael's Cardiac Clinic.

Autopsy studies noted by Dow [2] revealed no anatomic difference between the right and left branches of the main pulmonary artery—although I wonder whether careful measurements of the diameters at the point of bifurcation of the main parent vessel may not disclose a diminished orifice of the right pulmonary artery. As yet, I have not had an opportunity to make such measurements. It may be that the expansile pulse in the left pulmonary artery is actually due to the direct propagation of the jet generated by the

6. Sobin, S. S., Carson, N. J., Johnson, J. L. and Baker, C. R.: Pulmonary Valvular Stenosis. American Heart Journal, 48:416 (Sept. 1954).

7. Brewer, A. J. and Brandenburg, R. O.: Pulmonic Stenosis: Roentgenographic Appearance in Patients More Than 34 Years of Age. Proc. Staff Meet., Mayo Clinic, 32:567 (Oct. 1957).

stenosed pulmonic valve into the left pulmonary artery, since the latter vessel is essentially a direct continuation of the main pulmonary artery posteriorly, in contrast to the right pulmonary artery which angles fairly acutely to the right. An intriguing possibility is that the rapid streaming of blood from the main pulmonary artery to the left pulmonary artery past the orifice of the right branch may exert a vacuum effect and thereby reduce the filling of the right pulmonary artery, causing it to be diminutive in comparison to the left branch. This, however, is only a matter for conjecture at this point.

SUMMARY

1. Seven instances of the fluoroscopic observation of an appreciable expansile pulsation of the left pulmonary artery in association with a quiet right pulmonary artery were noted in a group of thirty-six patients with valvular pulmonic stenosis without over-riding of the aorta from 1952 to 1956.

2. As increasing awareness of the importance of fluoroscopy in the diagnosis of pulmonic stenosis was appreciated, the observed frequency of this finding rose to ten out of fifteen consecutive cases observed and established between 1956 and 1958.

3. In a larger group of patients with congenital heart disease this observation has been seen only in congenital absence of the right pulmonary artery.

4. This finding of asymmetric pulsation of the branches of the pulmonary artery is presented as a reliable sign, when present, of valvular pulmonic stenosis.

825 South Tenth Street

Contact Lenses for Teenagers

Because of the increased recognition that social acceptance is important to children in their early teens, contact lenses now may be prescribed for this age group. The corneal contact lens gives a better cosmetic effect and is better tolerated but offers less protection to the eye than does the scleral contact lens. The latter is excellent for swimming or other sports—the corneal lens is not adaptable for these purposes—J.A.M.A., June 14, 1958.

Pony Hairdos

A symmetrical loss of hair at the border line of the scalp may be seen in girls and women with ponytail hairdos, according to an Austrian physician. A Scandinavian study pointed out that "Eskimo women who used to comb their hair backward with some force and tie it in a pigtail had spots of reduced hair growth in certain areas of the head. Around the hairline a thin wreath of shorter hair remains standing which cannot be caught in the hairdo," the report said. Regression, degeneration and sometimes inflammation of the hair follicles will be found on examination. "The cause of this phenomenon is thought to be the forcible pull exerted on the hair during combing. The only treatment seems to be a change in the style of the hairdo."—*Postgraduate Medicine*, June, 1958.

Golden Merit Award Ceremony

192nd Annual Meeting

May 17, 1958

The Golden Merit Award ceremony was convened at 3:40 p.m., Dr. Kenneth E. Gardner, President, presiding.

The President: Officers and Members of The Medical Society of New Jersey, Officers and Members of the Woman's Auxiliary, Honored Guests, and Our Beloved Recipients of the 1958 Golden Merit Award:

It is my privilege, as President of The Medical Society of New Jersey, to officiate at this, the second annual bestowal of the Golden Merit Award. The Award was established in 1957 as an expression of The Medical Society of New Jersey's pride in, and affectionate regard for, those members who have completed half a hundred years as doctors of medicine. In bestowing this award The Medical Society of New Jersey honors itself by identifying itself with those distinguished men and women who have given a lifetime of devoted service to the people of New Jersey.

The growth of medicine as a profession is measurable in terms of new research findings, new treatments, and new technics. Its greatness and its glory, however, spring from the constancy and selfless devotion of the men and women who make that growth possible and who bring to the bedside of their patients the benefits of the advances that are made. Practitioners of medicine are ministers of mercy who, with compassion in their hearts and healing in their hands, bring to the suffering sick whom they tend the hoped for "peace out of pain." All mankind owes a debt to such as they. The Medical Society of New Jersey hopes in these ceremonies today at least to acknowledge some of that debt, which it can never hope to repay.

Last year, the first year of the presentation of this award, there were, in all, 177 recipients. The combined years of service rendered by these recipients represented a grand total of 8850 years—8850 years of duty and service, of labor and of love!

This year our group is necessarily smaller because, in the first bestowal, awards were conferred upon those who held their degrees for fifty years or more. With one exception, this year's recipients received their M.D. degrees in 1908. Twenty-six they number, and their collective offering on the altar of service is 1300 years.

I cite these figures, realizing full well that we do not acclaim these, our venerable colleagues, merely for the length of time that they have served, but because in a world of transient and inconstant worth they have served so long and so extremely well.

My dear colleagues, one would need the golden voice of a poet properly to express our delight and indebtedness today. Let me but simply say, for all the members of The Medical Society of New Jersey, for all the people of our State, for all your generation, which by your living and giving you have profoundly enriched—thank you and God bless you!

I should like to share with you a stanza written in appreciation by one of the jubilarians whom today we salute—Dr. Henry Ameroy Hartwell, poet-physician from Hudson County—who, I feel sure, speaks for all his honored colleagues:

> Some pillars that we build may long endure,
> While others shake and crumble into rust.
> The few that bend are never quite secure,
> for Time disburses all in arid dust.
> But you have built a diamond in my heart
> No storm, nor winds of Time, can tear apart!

May this prove to be the case for all of you, my beloved colleagues, and may you, for many years, remain to inspire and encourage us and to enjoy the deserved rewards of your generous and gifted contributions to the general good of all. Thank you. (Applause)

I now present Dr. Kustrup, who is the Chairman of our Public Relations Committee and who has charge of this portion of the program.

Dr. Kustrup: Mr. President and friends

of the recipients: I will first call out the list of those to receive the Golden Merit Award. I will then call out the list of recipients who are here present. They will be escorted to the front of the auditorium and will receive their award from the President. The escorts will be the marshals of their county society; in most cases the president will act as marshal. For Monmouth County, Dr. Don Reynolds will escort his father, George G. Reynolds.

(The awards were then presented by the President).

List of Recipients

Atlantic County
Samuel Elias Weiner, Atlantic City

Camden County
Mabel Summer Haines, Audubon
Ralph King Hollinshed, Westville
David Samuel Rhone, Mount Ephraim

Essex County
Joseph Albano, Newark
Abraham Jacob Alexander, Newark
Rush Clettis Bauman, Nutley
John Huberman, Newark
Otto H. Leber, Montclair
Otto George Matheke, Newark
Jesse Elbertus Proctor, Newark
Albert Seward Tenney, East Orange
Edward P. Whelan, Nutley

Gloucester County
Henry Llewellyn Sinexon, Pitman

Hudson County
Michele Auriemma, Hoboken
Henry Ameroy Hartwell, Weehawken
Louis Charles Lange, Weehawken

Mercer County
Lawrence Harrison Rogers, Trenton

Monmouth County
George Goff Reynolds, Freehold

Ocean County
Eugene Garfield Herbener, Lakewood

Passaic County
Hagop Kevork Beshlian, Preakness
William Marvell Fielding, Waldwick
John Howard Gould, Ridgewood
Ernest Reeves, Passaic
William Tomkins, Ridgewood

Union County
John Edmunds Runnells, Scotch Plains

Obituaries • • •

DR. HARRY B. EPSTEIN

Harry Epstein was one of the colorful figures of New Jersey surgery. He was not only a distinguished surgeon—he was a pharmacist, a pathologist, a war veteran, a civic leader and a well-known Shakespearean scholar. Born in Elizabeth in 1872, he was graduated from the New York College of Pharmacy in 1890 and from the medical school at Bellevue in 1896. He was, at one time or another, attending or consulting surgeon at St. James Hospital, Martland Medical Center, Beth Israel, Presbyterian, Orange Memorial and East Orange General. He was one of the founders of the Babies Hospital, an F.A.C.S. and a member of many professional societies. He was long interested in anatomy and pathology and was president of the Anatomic and Pathologic Society. Dr. Epstein also served as president of the Northern N. J. Academy of Medicine. He was the author of the unique book, *William Shakespeare, M.D.*, and was in wide demand as a lecturer on Shakespeare.

Dr. Epstein died on November 28, 1958.

DR. GEORGE A. SEYMOUR

Dr. George A. Seymour, past president of the Union County Medical Society, died on December 1, 1958, while visiting his son in Somerville. Dr. Seymour was born in New York City in 1887. He moved to Jersey City in childhood and received his medical degree from the College of Physicians and Surgeons in Baltimore in 1910.

He then came to New York to become an intern at the Lying-In Hospital there, and soon thereafter moved to Elizabeth, New Jersey. Although he devoted much of his professional activity to eye, ear, nose and throat work, he always considered himself a general practitioner and family doctor. He was on the staff of all three hospitals in Elizabeth. He was also active in Masonic affairs and in the work of the Union County Medical Society. At the time of his death he was medical director of the Plainfield Regional Defense Blood Center.

DR. JOHN H. WINSLOW

On November 15, 1958, Dr. John H. Winslow, one of the grand old men of New Jersey medicine, died at his home in Vineland. Dr. Winslow was born in 1878. In 1901, he received his M.D. degree from the Jefferson Medical College. He returned to Vineland and became active in many civic and medical affairs. He served as president of the Newcomb Hospital board. He was president of the Vineland Board of Education. He was one of the founders of the local Kiwanis Club. He was active in fraternal affairs and he served the Cumberland County Medical Society in many capacities for many decades. During his funeral, the fire whistles throughout all Vineland sounded off as a tribute to the esteem and affection which Cumberland County felt for Dr. Winslow.

Announcements • • •

Lecture on Space Medicine

On Thursday, February 5, at 8:30 p.m. a lecture on space medicine will be held at the New York Academy of Medicine, 2 East 103 Street, New York City. The speaker, Dr. Hubertus Strughold, is professor of space medicine at the Randolph Air Force Base in Texas. This is part of the Biggs Lecture series given under the auspices of the New York Academy of Medicine since 1925.

Philadelphia Graduate Institute

The Twenty-Third Annual Postgraduate Institute of the Philadelphia County Medical Society will be held March 17 to 20 at the Bellevue-Stratford Hotel in Philadelphia. Registration fee for non-members is $10. Among the topics to be covered are hypertension, deficiency diseases, x-ray hazards, injuries, problems of the teenager, and coronary heart disease. For information write to Dr. C. W. Wirts, 301 South 21st Street, Philadelphia 3.

Personality Development Lecture

The Association for the Advancement of Psychoanalysis announces the Seventh Annual Karen Horney Lecture to be given by Dr. Leo Kanner on "Centripetal Forces in Personality Development." The meeting will be held on March 25, at 8:30 p.m., at the New York Academy of Medicine, 3 East 103 Street, New York City. All readers of this JOURNAL are welcome to attend.

Diseases of the Chest

The American College of Chest Physicians will present a postgraduate course on diseases of the chest at the Sheraton Hotel, Philadelphia, March 30 to April 3, 1959. Recent advances in the diagnosis and treatment of heart and lung diseases, medical and surgical aspects, will be presented.

Tuition for this five-day course will be $100, including luncheon meetings.

Further information may be obtained from American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Eye and Ear Symposium

April 20 through 23 are the dates for symposia on EENT to be held at the New York Eye and Ear Infirmary. Seminars will be held on headache, contact lens fitting, allergy in ophthalmology, rhinoplasty, hearing rehabilitation, neck surgery, ophthalmic plastic surgery, orthoptics and many other topics related to laryngology, rhinology, otology and ophthalmology. For full program and other details, write to Dr. John R. Finlay, Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Marginalia of Medicine • • •

This section is for comments, queries, answers and footnotes. Each item is preceded by a bold-face numeral. When writing, please identify the item by that numeral. Address your questions—and answers—and comments to "Marginalia" care of the Editor, The Medical Society of New Jersey, P.O. Box 904, Trenton 5, N. J.

11

A worried nurse wants to know if a patient might suffer a fatal mercury poisoning by swallowing a thermometer bulb that has broken in his mouth.

The question was sent in a month ago, so the answer by now is academic. Dr. Gerarde, the toxicologist in Esso here in Linden, says that the amount of mercury so ingested is harmless. This appears in the book *Signs, Symptoms and Treatment of Acute Intoxications* by Dr. Gerarde, co-authored by Professor William Deichmann and published last year by Charles C. Thomas of Springfield, Illinois.

12

A doctor who recently moved his practice from New York into Bergen County, New Jersey, asks if it is true that, under New Jersey law, an M.D. can be compelled to testify as to what a patient told him in confidence—and that the physician has to do it even if the patient objects. He says that in New York such statements by the patient are "privileged."

The doctor is right both times. What a patient tells the doctor is privileged in New York if the communication was necessary for treatment. But not in New Jersey where the practitioner can be held in contempt of court if he refuses to testify as to what the patient told him. The New York position is that it is in the interests of human health to encourage complete confidence in the physician. The New Jersey position is that at a trial the only business is to get at the truth; and that no one, not even an M.D. has the right to throw sand in the machinery of justice by withholding a truth that is necessary to justice. One New Jersey judge told us, in answering this question, that if a certain fact were necessary to justice, the physician should not be permitted to suppress it. For instance, said the judge, an orthopedist knew that Mr. X had a lumbosacral disorder for 10 years. Now he is suing a perfectly innocent taxi driver, alleging that he wrenched his back getting out of the cab. By pleading "privilege," the doctor could thwart justice and make the taxi driver liable when he really wasn't. Any of our members care to comment on that?

13

"Forgive me for asking" writes a literary friend who is not a physician, "forgive me for asking, but what is the origin of the word *quack*, meaning a medical charlatan?"

Take your choice. It either is a corruption of "quicksilver" (via *quacksilver*) or it comes from the harsh cry of the duck. The quicksilver school contends that peddlers in the Middle Ages sold mercurial ointments to cure syphilis. Mercury was then called quicksilver which was corrupted to quacksilver. So any ill-trained medicine man became a quacksilver, then a quacksayer, then a quack. Others say that the word for the duck's cry simply became a symbol of any vain boasting; and then came to be applied to those who falsely boasted of their skill and their cures.

County Societies Reports • • •

Atlantic

Dr. Louis Rosenberg, the vice-president, opened the meeting at nine o'clock on October 10, 1958 at the Children's Seashore House.

Dr. Molitch introduced the visiting speaker, A. Wilbur Duryee, M.D., Professor of Clinical Medicine, New York University Post-Graduate Medical School. His subject was "Medicolegal Aspects of Cardiac and Peripheral Vascular Disease." There was discussion by Drs. Allman, Gleason and Rosenberg.

The Censorship Committee approved the elevation of Dr. Robert Datesman from Associate membership to Regular membership. The Society voted unanimously to accept Dr. Datesman as a Regular member. Vincent A. Morrone, M.D., Samuel Stetzer, M.D. and Robert Allman, M.D., were all elected to Associate membership.

The treasurer reported that the new Society office has been established at the Atlantic City Hospital and that secretarial service was obtainable by any member on official county business. Speaking for the Emergency Medical Service, Dr. Donald Davidson explained the present emergency service. There was considerable discussion as to the letters sent out to members under 45 years of age who will be called upon to cover the emergency service on a certain day of each month. It was suggested that all doctors under 45, even though in a specialty, should be on the list of practitioners giving this service. It was also noted that this service was not a "check out" for doctors to use at night or whenever they are leaving the city. Dr. Allman emphasized the importance of the work of this committee.

Every doctor who knows of a patient using an iron lung is asked to notify the secretary so that a list of patients might be kept at the Electric Company. Thus emergency service can be rendered to these patients in case of disaster.

L. B. ERBER, M.D.

Reporter

The Society adopted a memento of the services so ably performed by its deceased contemporaries: Horace Loder, M.D., of Bridgeton, Charles Gray, M.D. and John Winslow, M.D., of Vineland.

The speaker was Louis Tuft, M.D., Chief of Allergy Clinic, Temple University Hospital. His subject was "Newer Developments in the Diagnosis and Treatment of Bronchial Asthma." Dr. Tuft interestingly and instructively classified asthmatics and developed the concept that it can be a symptom complex of the bronchial tree rather than a specific disease, *per se*.

The well attended meeting adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Essex

The *Essex County Medical Society* met on November 13, 1958 at the Veterans Administration Hospital in East Orange. Dr. Herbert J. Schaefer presented a paper on the cytologic diagnosis of carcinoma in the tracheo-bronchial tree. Dr. Schaefer stated unequivocally that cigarette smoking was the most important single cause of lung cancer. The next speaker was Dr. Stephen R. Lovemc, who discussed reconstructive phalloplasty. This paper included a presentation, for the first time in medical history, of a compartmented pedicle tube-within-a-tube with an autogenous cartilaginous insert which, in a 40-year old man, proved both functionally and cosmetically satisfactory. The final speaker, Dr. Edward Kessler, talked on practical problems in electrolyte balance and imbalance. A collation was served at the conclusion of the scientific program.

WILLIAM A. ANDERSON, M.D.

Reporter

Cumberland

The December meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake, on December 9, 1958, with Benjamin Berkowitz, M.D., of Bridgeton, President-elect, presiding in the absence of the president, M. David Baxter, M.D.

The Society unanimously accepted the transfer of John Francis Fitzgerald, M.D., to Associate membership in Cumberland County Medical Society from Federal Service membership in the Medical Society of County of Kings, New York State.

Gloucester

The *Gloucester County Medical Society* met as usual on the third Thursday of November, the 20th, 1958, on invitation of the Owens-Illinois Glass Company in Glassboro. A tour of the plant preceded the meeting.

Dr. Luke Jordan, Professor of Orthopedic Surgery at The Woman's Medical College, Philadelphia, spoke on "The Problem of Back Pain." Dr. Jordan deplored the all-too-frequent diagnosis of "ruptured disc" and stated that is the *least* common of all causes of back pain. Conservative measures are the best early treatment and may be best

throughout the need for treatment. He stated the muscle relaxants are not as helpful as was anticipated, but analgesics are important as well as inactivity, follow-up, possibly steroids for injection, traction, surgery. If rigid immobilization does not relieve, neither will fusion relieve.

Doctors were urged to contribute individually to the Student Loan Fund.

Attending members reported ample reward for being present at the Annual Banquet and Social Session in October at the Tavistock Country Club in Haddonfield. Kenneth E. Gardner, M.D., President of The Medical Society of New Jersey, and Dr. Pierre C. Simonart, Professor in Graduate School of Medicine, University of Pennsylvania, were speakers.

DOROTHY M. ROGERS, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center, on December 2, 1958. Dr. John J. Bedrick presided.

Guest speaker was Dr. William Grace, Professor of Clinical Medicine, New York University Medical School. The topic of the talk was entitled "The Results of Treatment in Various Clinical Syndromes."

The Society passed the following resolutions:

Whereas in the recent edition of the *Jersey Journal* it was stated that the Hudson County Board of Freeholders is going to sponsor a prepayment medical care plan which would take care of private patients in the home and

Whereas, the doctors who comprise the Hudson County Medical Society will be called upon to render this care to the patient; and

Whereas, the Hudson County Medical Society has not been consulted in any way in the formulation of this plan and

Whereas, the Hudson County Medical Society has never been notified of the plan;

Be It Resolved, that the Hudson County Medical Society respectfully requests that the Board of Freeholders invite the Hudson County Medical Society to participate in the negotiations necessary for establishing this proposition.

The following resolution was also passed:

Whereas, 80 per cent of the cases in the trial courts of the country are personal injury cases involving the taking of medical testimony, and,

Whereas, the medical testimony is given by partisan doctors retained by the respective parties with the result that the medical opinion is frequently conflicting and,

Whereas, the medical profession is interested in seeing that justice be done to the parties involved,

Be It Resolved that the Hudson County Medical Society recommend that The Medical Society of New Jersey appoint a committee to act with a similar committee of the New Jersey Bar Association for the purpose of setting up a panel system of medical specialists, similar to the panel in the New York courts, who will be available to be called by the courts as independent medical experts whenever there is a conflict in medical testimony or when the Judge thinks that additional medical testimony is needed, and,

Be It Further recommended that The Medical Society of New Jersey petition the Supreme Court of New Jersey to change court procedures so that the testimony of the medical experts on the panel would be admissible as evidence.

The following resolution was also adopted:

Resolved that Boards of Health in respective areas be advised that Pre-marital serologic tests also require a physical examination to be done by a qualified physician to eliminate clinical signs of venereal disease. Examinees should, therefore, be referred to family physicians or to a panel of doctors from which a selection may be made by the examinee.

Elected to membership were Dr. Joseph M. Caterini of Newark and Dr. Charles A. Petersen of West New York.

CLEMENT M. JONES, M.D.

Reporter

Middlesex

With Dr. George J. Kohut presiding, the monthly meeting of the *Middlesex County Medical Society* was called to order at Roosevelt Hospital, Metuchen at 9:00 p.m., November 19, 1958.

Dr. Mary Ellen Kennedy, New Brunswick, was elected to Regular membership from Associate membership and Drs. James S. Wales, Perth Amboy and Joseph Zawadsky, South River, were elected to two-year period of Associate membership.

Dr. William Rubin, chairman, reported that the Public Relations Committee recommended that poliomyelitis clinics be set up in hospitals in Middlesex County to give Salk vaccine on specific days for a fee of $1.00. This would cover a period of three months. Physicians would be selected from among volunteers. Proceeds from this service will be used for new hospital equipment. Vigorous discussion followed. Many said that the best place to give vaccine was in the physician's office. Dr. Fine suggested that this was a Public Health rather than a Public Relations problem. The matter was referred to both committees working together for a solution.

Dr. Avron Sweet, Director of Respiratory Center at Mount Sinai Hospital, New York City, spoke about the "Peculiarities and Symptomatology in Chronic Poliomyelitis Patients." He stressed the value of the Salk vaccine in lowering the incidence of paralytic poliomyelitis. This was proved by 1958 statistics collated from various cities throughout the U.S.A.

Dr. E. J. Tyrrell, secretary, read a request from the Bergen County Medical Society for a poll of our membership as to whether we favored compulsory inclusion in Social Security. A poll by

postal cards will be made. The Bergen County Medical Society favored inclusion and had presented this to the State Society. They now desired to know if the other county medical societies also favored inclusion.

The Society gave unanimous approval of the annual payment of yearly bonus to the waitresses at Roosevelt Hospital.

DONALD T. AKEY, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on November 18, 1958 at the Valley View Hospital. The President, Theodore K. Graham, presided.

The following were elected to active membership: Drs. Herbert L. Cole, Charles M. Lewis, Herbert S. Rosenthal, Victor J. Weill, Edward A. Wolfson—all of Paterson; Drs. Oscar J. Krieger and Roy R. Singer of Fair Lawn; Dr. Charlotte Lomova of Clifton.

Resolutions on the death of two members of the Society, Dr. Owsley B. Duncan and Dr. Hiram Williams, were then read and adopted.

Dr. Samuel T. Bernson extended an invitation to attend a professional symposium of the Morris and Passaic County Heart Associations at Pompton Plains.

The meeting was then turned over to Dr. Homer H. Cherry who introduced the guest speaker, John L. Pool, M.D., Assistant Clinical Professor of Surgery, Cornell Medical College. Dr. Pool's subject was "Cancer of the Lung, Indications for Treatment and Comparative Methods." A question period followed.

Dr. Cherry, Superintendent and Medical Director of the Valley View Hospital, then invited the members to a late supper.

DAVID B. LEVINE, M.D.
Reporter

Salem

The *Salem County Medical Society* held its regular meeting on November 21, 1958 at the Salem County Memorial Hospital.

The speaker for this meeting was James Butcher, M.D., Assistant Professor of Pathology at University of Pennsylvania School of Medicine and Pathologist at Presbyterian Hospital. His subject was Malignant Lymphomas, including acute and chronic leukemia. With the aid of slides he outlined the various types of diseases in this category along with the variations that might be encountered and then developed the methods of treatment.

Dr. Charles E. Gilpatrick presided at a short business meeting at which time the question of compulsory Social Security for physicians was discussed. Drs. August Jonas, William Sprout, and Spencer Davison were appointed to secure information on this subject for presentation to the Society at the next meeting.

Dr. George Nitshe outlined the programs for the remaining meetings.

Dr. Jonas, a member of the Advisory Committee to the Vocational School of Salem County, reported that he was favorably impressed by the teaching program presently in use. He asked the cooperation of the Society members in securing applicants for the next year's class in the Practical Nursing Course.

At the close of the meeting the Salem County Memorial Hospital, through Dr. James Menges, Administrator, was host to the Society for dinner.

G. F. REICHWEIN, M.D.
Reporter

Union

The regular meeting of the *Union County Medical Society* was held on November 12, 1958 at White Laboratories, Kenilworth.

The president, Dr. Graham C. Newbury, conducted a brief business meeting during which the Society approved a report presented by Dr. Francis A. Merlo, chairman of the public health committee, which proposed that the Union County Medical Society recommend that all new students in the schools should have had their Salk vaccine immunization or should be in the process of receiving the immunization before admission to school. It was also recommended that all persons under forty years of age be encouraged to secure immunization with poliomyelitis vaccine.

Drs. Anthone E. Abramo and Ralph Wilmer, Jr., of Summit; Dominic A. Introcaso and Aurelio Romeo of Elizabeth; and Martin D. Liemer of Plainfield were elected to Associate membership.

Drs. Arthur Barletta, Harry C. Cramer and Joseph R. Hrab of Elizabeth; Edmon B. Lee and Paul A. Minour of Cranford; Robert S. Jordan of Linden; Sanford W. Reiss of Westfield and Harry Simon of Berekeley Heights were elected to Active membership. Dr. Watkins F. John of Cranford was received as a transfer from Hamilton County, Ohio; Dr. Stanley D. Malton of Cranford was received as a transfer from Bronx County, New York and Dr. Victor H. Raimo of Elizabeth was received as a transfer from Essex County, New Jersey.

Following the business meeting, Mr. Richard Nevin, Executive Officer of The Medical Society of New Jersey spoke briefly on *What Lies Ahead for Medicine*.

Principal speaker of the evening was Dr. Kenneth Gardner, President of The Medical Society of New Jersey. Dr. Gardner extended greetings from the state society and spoke briefly on the function and duties of physicians as citizens. He emphasized that freedom of enterprise had made America a great country, and encouraged those present to be enlightened and public spirited citizens as well as good physicians.

E. H. POGUE, M.D.
Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

What We DO Know About Heart Attacks. By John W. Gofman, M.D. Pp. 180. New York 1958, G. P. Putnam's Sons. ($3.50)

Dr. Gofman, a brilliant research worker in atherosclerosis, has taken time out from his work to write a short summary in what he considers to be layman's language, of the work in which he has been engaged for the past few years. The book probably should be entitled *Mein Kampf*, because here he carries his battle on the "atherogenic index" and the Sf molecule to the public, from the medical arenas where he has been so badly mistreated. Dr. Gofman sets up a group of straw men. Then with a brilliant barrage of rhetoric, he destroys them and in so doing "proves" that the Sf molecule and the atherogenic index are the key to the entire problem of atherosclerosis and therefore coronary artery disease and ultimately to an extended life span. If one grants Dr. Gofman's basic premises and does not know of the mass of evidence that controverts many of his facts, one must be convinced that the answer lies in this book. This becomes even more convincing when he "proved" that even occupation and cigarette smoking play a role in the level of the atherogenic index. So he says, they too tie in with his theory, that all atherosclerosis is related to the lipoprotein level based upon the ultra-centrifugation method. The anti-climax of the book, however, is the fact that after he has so brilliantly "proved" his point, and shown the need for lowering fat by diet, the reader is referred to his other book, "The Dietary Prevention and Treatment of Heart Disease," to find how to achieve the goal which he so brilliantly, though biasedly, presents in his book.

The paper used in the book is not the best and the printing is a little hard upon the eyes of the reader. In addition, the language used, seems to me to be better adapted for the physician who wants a quick summary of Dr. Gofman's ideas than the layman. In many places the book is much too technical for the average individual to understand. There are three interesting illustrations of lipoproteins as viewed through the electronmicroscope. It would probably have been of value to have pictures of the ultra-centrifuge and how the Sf levels are read for a better understanding of Dr. Gofman's thesis.

In summary, then, this book, written for the layman, tells in rather technical language, the story of Dr. Gofman's research over the past years, as well as his ideas and conclusions on the causes and methods of prevention of atherosclerosis and coronary artery disease. The presentation of the weighted facts and the omission or brushing aside of all controversies present a hopeful picture to the layman and will probably be grasped by all sufferers who are anxious for some safe haven in which to anchor—if it were only that simple.

ARTHUR BERNSTEIN, M.D.

The Only Baby. By Sheldon Cholst, M.D. New York 1958. Whittier Books. Pp. 72. ($2.50)

Now this is a book of poetree—written in a verse style once called free—centered on some phases of psychiatree—that are not quite as easy as A.B.C.—And for some of the verses you will need a key—I'm sure it's noble as a book can be—but, alas, this work is too deep for me.

RALPH SHAPIRO, M.D.

The World of Psychic Phenomena. By Florence S. Edsall. New York 1958. David McKay. Pp. 244. ($3.95)

Like all natural scientists, we are unwilling to believe in brownies, witches, magic, poltergeist, or telepathy. Science has spent centuries in disabusing people of these notions. We don't want to fight that all over again. This anxiety has tended to close our minds to the evidence of extrasensory phenomena. Most of us will not seriously investigate stories of clairvoyance or telepathy. We assume that it is all nonsense. Yet this attitude is a kind of bigotry, because we won't look at the evidence.

In this compact book, Mrs. Edsall has given us a readable, straightforward presentation of the evidence for a number of "paranormal" phenomena.

The text is written with good pace and with none of the truculence which so often characterizes *apologia* for the supernatural. Anecdotes are recited, evidence is weighed, theories are reviewed, frauds are exposed, and experimental methods are presented. The book is not intended to propagandize nor to convert, but rather to inform and entertain. And it is a solid piece of scholarship. To date there has been no really conclusive evidence of the existence of extrasensory perceptive channels. Yet only a fool would say that the book of knowledge is now forever closed. It is unscientific to assume that the present limits of our sensory powers must also be the ultimate and eternal ceiling of nature itself. And this little book is a good introduction to that possible world of psychic phenomena.

HENRY A. DAVIDSON, M.D.

The Road to Emotional Maturity. David Abrahamsen, M.D., Englewood, N. J. 1958. Prentice-Hall. Pp. 388. ($4.95)

While there is no shortage of self-help-to-happiness books, this one is decidedly better than average. Dr. Abrahamsen has managed to steer between empty generalities on one hand, and incomprehensible psychiatric jargon on the other. The book is a treatise on the normal man, and not a study of the neurotic. It contains some interesting and practical material on self-examination. The author's goal is "emotional comfort" and he discusses the many road-blocks on the road to emotional maturity. A unique feature of the text is a 16-page insert which offers a yardstick for self-exploration, in which the stumbling blocks are listed on one page and the desirable corresponding feelings and actions are detailed on the page opposite. This book is a road-map through the most enchanting land of all, yourself. It is a useful source book, too, for the physician who is called on to give a talk on emotional maturity to a nonmedical group. It is a valuable ingredient in the prescription of any doctor who wants to advise a worried patient on authoritative self-help reading.

HERBERT BOEHM, M.D.

Rehabilitation Medicine. By Howard W. Rusk, M.D. and 36 collaborators. With the editorial assistance of E. J. Taylor. St. Louis 1958. Mosby. Pp. 570. ($12.00)

Rehabilitation is the most challenging concept to face medicine in a long time. It is not like convalescence, where the patient is left to rest while nature takes its course. It is not like prevention. It is a dynamic, imaginative program which seeks to eliminate a disability or retrain the person who has one.

Much of rehabilitation has escaped from the physician. The team includes occupational therapists and speech therapists, psychologists and pedagogues, prosthetic technicians and nurses. Dr. Rusk believes that the physician should maintain a central role—and he calls his book Rehabilitation Medicine as if to emphasize his concept of this as a branch of medical practice. A critic might, perhaps, say that this book is overweighted on the mechanical and orthopedic side; but the more obvious disabilities do tend to be mechanical. The chapter on "social problems" is scanty and superficial. The section on psychiatric problems is sensible. There is a unique and much needed chapter on "prescription writing," though here, too, the interpretation is mechanical. Thus, this chapter tells how to prescribe heat, massage, braces, hydrotherapy, ultraviolet, wheel chairs and the like, with no suggestions about the prescribing of social pressures, emotional aids, and other non-mechanistic resources.

But, taken all in all, this is a good basic textbook of tomorrow's medicine.

ULYSSES M. FRANK, M.D.

Crime and Insanity. Edited by Richard W. Nice. New York 1958. Philosophical Library. Pp. 280. ($6.00)

Like all anthologies this has its good chapters and its bad ones. The mechanical production is poor. The paper is pulpy. Some of the cross references are mixed up (example: citations 1 and 2 in chapter III) and some names are mispelled (example Judge Bazelon is called Bazelo on page 6). There are good workman-like chapters on irresistible impulse, on the Durham rule and on the proposed model code. Some of the other chapters are either amateurish or prolix. What shall we say of such items as: "Patients suffering from syphilis should not have spinal taps because such spinal taps often cause the patient to become a paresis case"? One of the authors is afraid that we are going to establish a "psychocracy" in America(!). Another author is so enchanted by his own phrases that he produces such mumbo jumbo as this: "Even if the law was fully identified with the conflicting and congruent conceptions of normalcy, it would still represent a state of social congealment typical of an historic process." It is unfortunate that the editor did not more smoothly integrate the chapters. Instead he has strung them together like beads on a string.

ABRAHAM LEFF, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

January, 1959 • Vol. XXXII—No. 1

WE LOOK AHEAD

The monthly "Tuberculosis Abstracts" now in its 31st year has changed its name in order to reflect more nearly the program of the National Tuberculosis Association and its affiliates and the interests of the general practitioner for whom it is issued.

Something new has been added! As you will note above, not only has the format been changed somewhat beginning with this first issue of *Abstracts* for 1959, but from now on these abstracts will be concerned with "other respiratory diseases" as well as tuberculosis.

Actually this is not a radical departure for the National Tuberculosis Association and its affiliated associations. For 35 years many of the affiliated associations have assisted in solving important local public health problems in addition to tuberculosis. For decades the tuberculosis associations have attempted to improve school health programs and have helped to promote adequate health departments. For almost three years the NTA itself, through official action of its Board of Directors in May, 1956, has been involved in the control of both infectious and non-infectious respiratory diseases. Little publicity has been given to this step since tuberculosis continues to be a major public health problem, and will continue to receive primary emphasis by the NTA and its affiliated state and local associations throughout the country so long as this is true.

CONTINUING IMPORTANCE OF TB

The present status of tuberculosis control in this country would lead one to think that the control of TB may require a long time. The case rates of tuberculosis have failed to decline as rapidly as the death rates. It is currently estimated that there are about a quarter of a millon active cases of tuberculosis in the United States, of which 100,000 are unknown to health officials and probably are not under medical supervision.

JAMES E. PERKINS, M.D., *Managing Director National Tuberculosis Association, October, 1958.*

While there are fewer patients under treatment in tuberculosis hospitals, there are increasing numbers being treated as "out patients." Unfortunately some of the latter group are not receiving adequate medical supervision.

TB AND OTHER RESPIRATORY DISEASES RELATED

The relationship between tuberculosis and other respiratory diseases is so intimate, particularly from the medical standpoint, that from the very beginning it has been impossible to be concerned only with tuberculosis and not with other respiratory diseases. Thus, silicosis, which notoriously plays an important role in precipitating the development of active tuberculosis disease, has been a concern of the NTA and its affiliates from the time of the founding of the NTA more than half a century ago. At the present time, through improved bacteriological methods, more and more illnesses clinically indistinguishable from tuberculosis are being recognized which are found to be due to mycobacteria similar to, but distinct from the *Mycobacterium tuberculosis*. There is an intimate relationship between tuberculosis and emphysema and chronic bronchitis, and outbreaks of influenza notoriously have been accompanied by a spiking of the tuberculosis death rate.

Respiratory diseases as a whole form a group of illnesses of tremendous public health importance which have been badly neglected in the past, and which the NTA, together with its medical section, the American Trudeau Society, and the affiliated tuberculosis associations, can be helpful in studying and bringing under better control. Based on a three year average of deaths in 1953-55, these diseases as a group (excluding cancer

of the respiratory system) are fifth in the list of causes of death, being exceeded only by heart disease, cancer, vascular lesions affecting the central nervous system, and accidents. If cancer of the respiratory system is added to the group, it becomes the number four cause of death.

So far as frequency of illness is concerned, rather than mortality, there is no question but that respiratory illnesses head the list.

GENERAL PRACTITIONER IMPORTANT

Why should this extension of interest be mentioned in an *Abstract* intended primarily for the general practitioner? The reason is that the general practitioner is the key person in the control of all of these respiratory diseases, including tuberculosis. As far as tuberculosis itself is concerned, with the development in recent years of effective drugs in the treatment of tuberculosis, the general practitioner has become even more important than he was before. He always has been a most fruitful source of finding cases of tuberculosis. The degree to which he keeps tuberculosis in mind as a possible cause of the symptoms which he notes in patients consulting him determines to a large extent how quickly tuberculosis is diagnosed, how soon the patient is put under adequate treatment, the patient's chances for recovery with a minimum of permanent disability, and the likelihood of spread of the disease to others.

Now that patients are discharged earlier from hospitals than before and at a time they must continue their therapy for many months after discharge, the general practitioner is a key man in determining the ultimate status of the patient. If he fails to keep the patient under adequate supervision and therapy for a sufficiently prolonged period of time, relapse is almost inevitable, resulting in an individual who is more likely to have a permanent disability if not an early death, and with the likelihood of further spread of the disease to his associates.

With regard to other chronic respiratory conditions, the practicing physician, again, is the key person with regard to detecting these in their early stages and putting the patient under adequate supervision and therapy to prevent the patient from becoming a chronic respiratory cripple. He is the key man in deciding whether or not the citizens in his community are adequately immunized against those respiratory diseases for which vaccines are available (or in which the respiratory system may be involved in transmission), such as diphtheria, whooping cough, smallpox, poliomyelitis, and influenza.

TB STILL PRIMARY INTEREST OF TB ASSOCIATIONS

The National Tuberculosis Association, its medical section, the American Trudeau Society, the state tuberculosis associations and Trudeau societies and the local associations will continue to devote their primary attention to the tuberculosis problem. They are also interested in trying to help in the solution of the other important respiratory illnesses plaguing mankind. They will promote good health in your community in close cooperation with the medical and nursing professions and public health officials. Through research, through community service, through education—new ways for attacking the broad problems of respiratory disease will be found.

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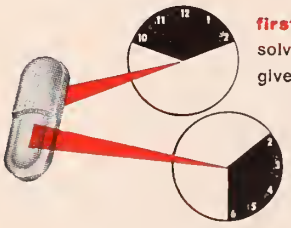
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†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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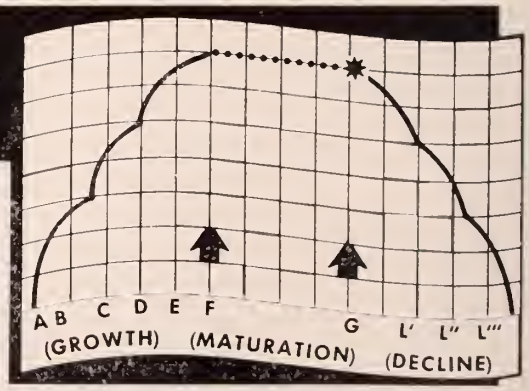
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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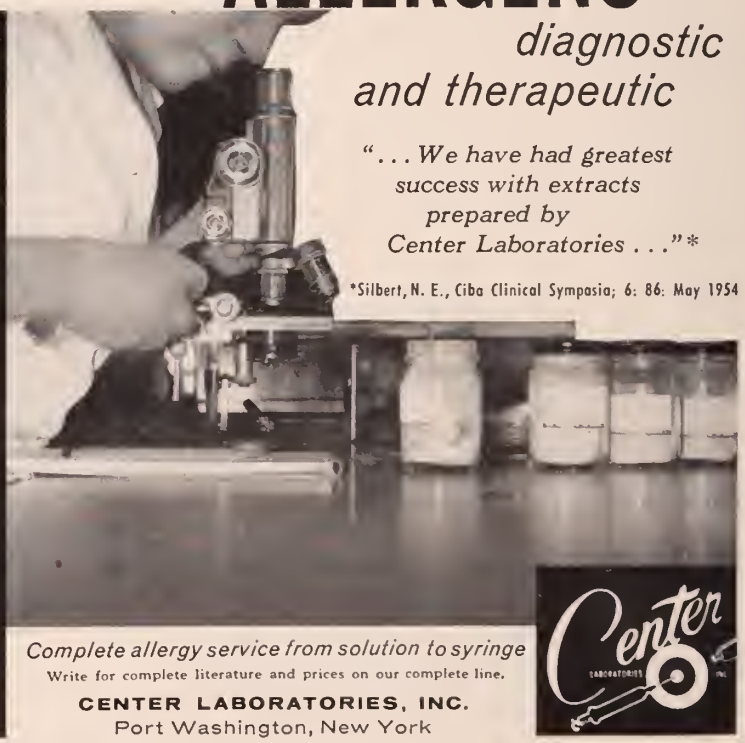
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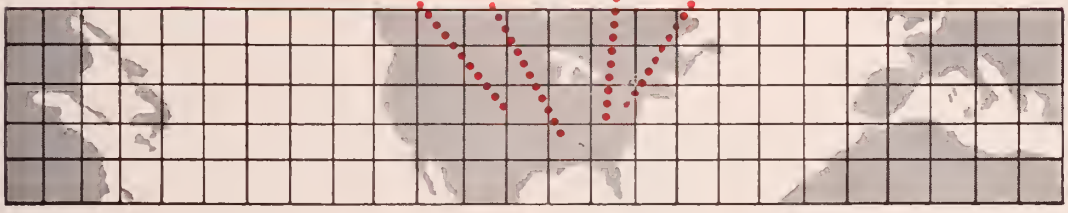
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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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1 Grienle, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958.
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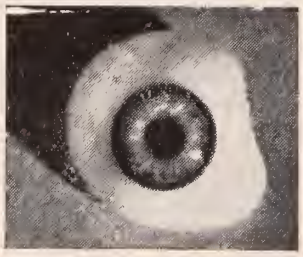
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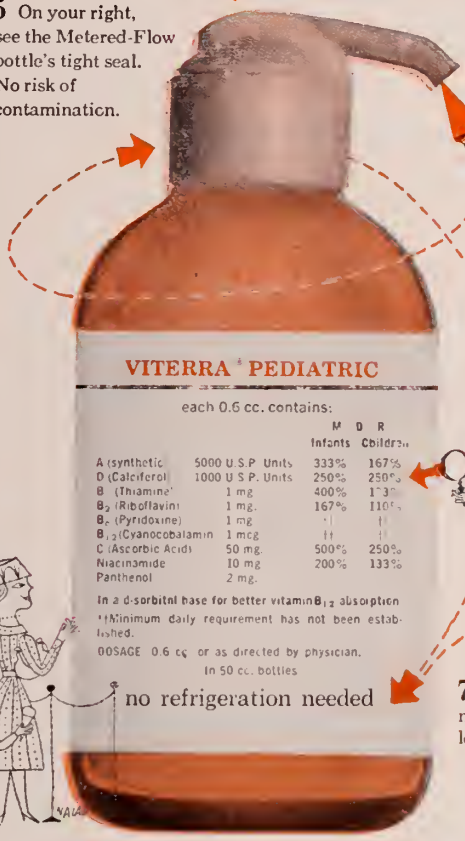
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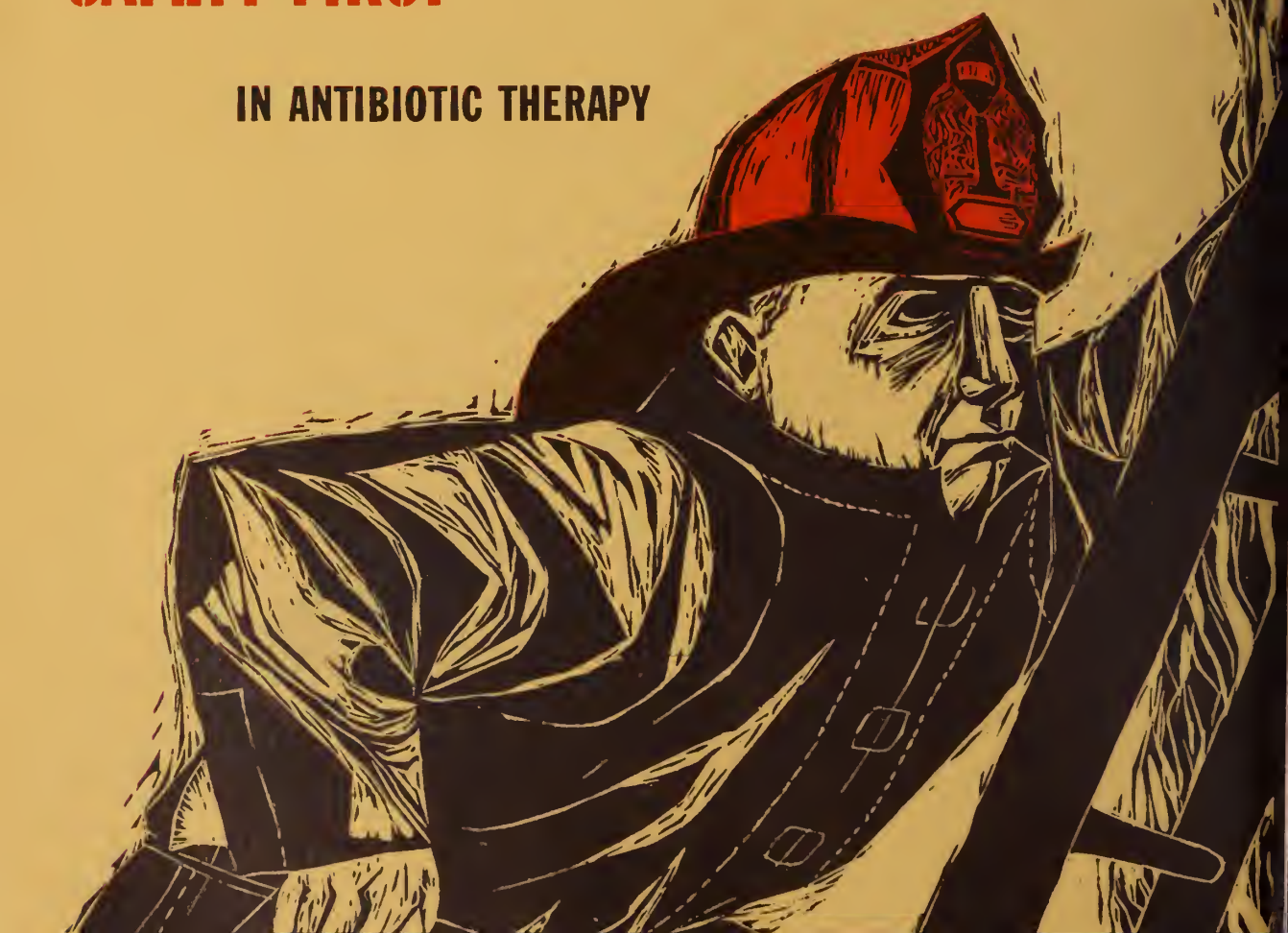
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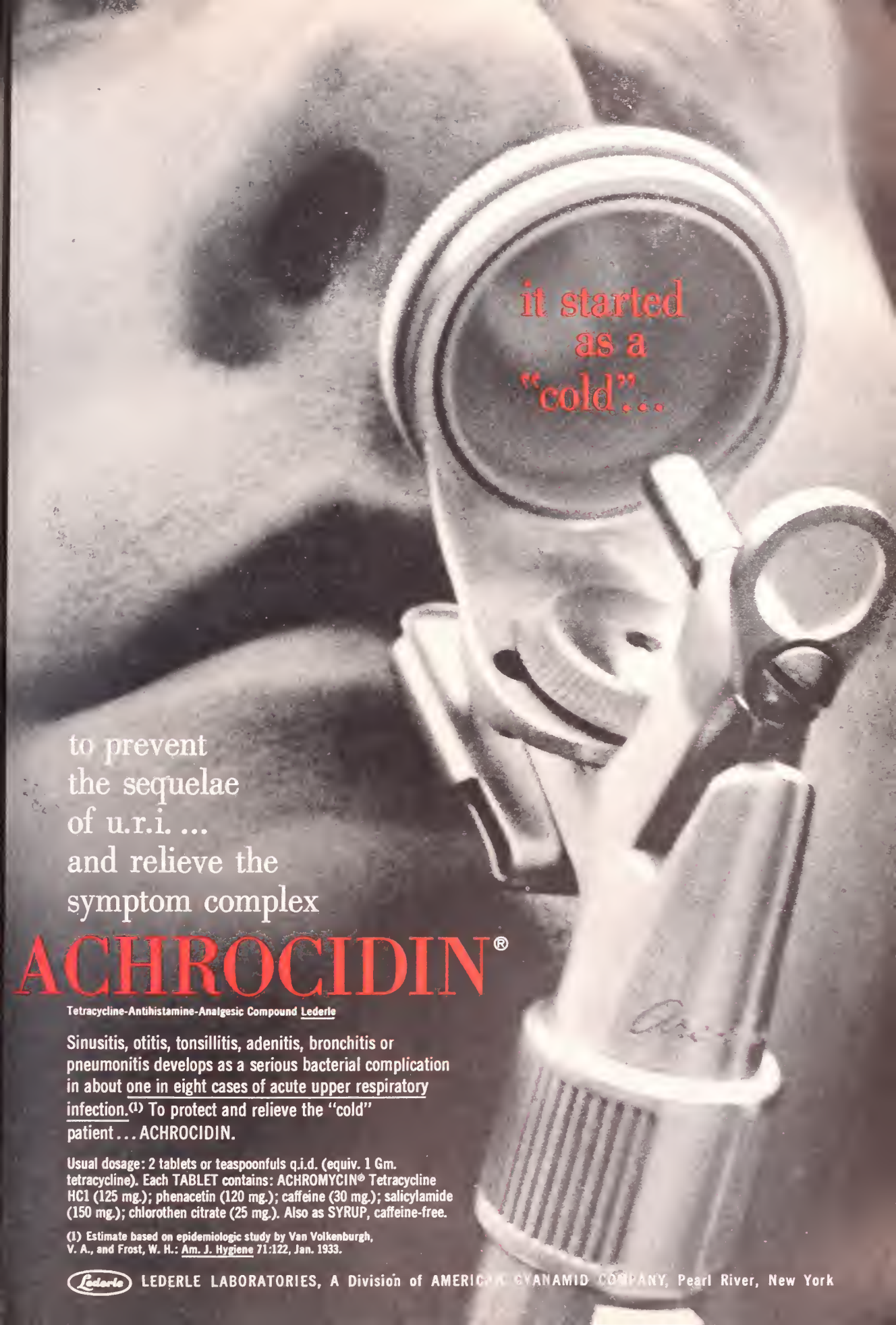
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on a Year's Clinical Experience
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In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded. "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

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Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"
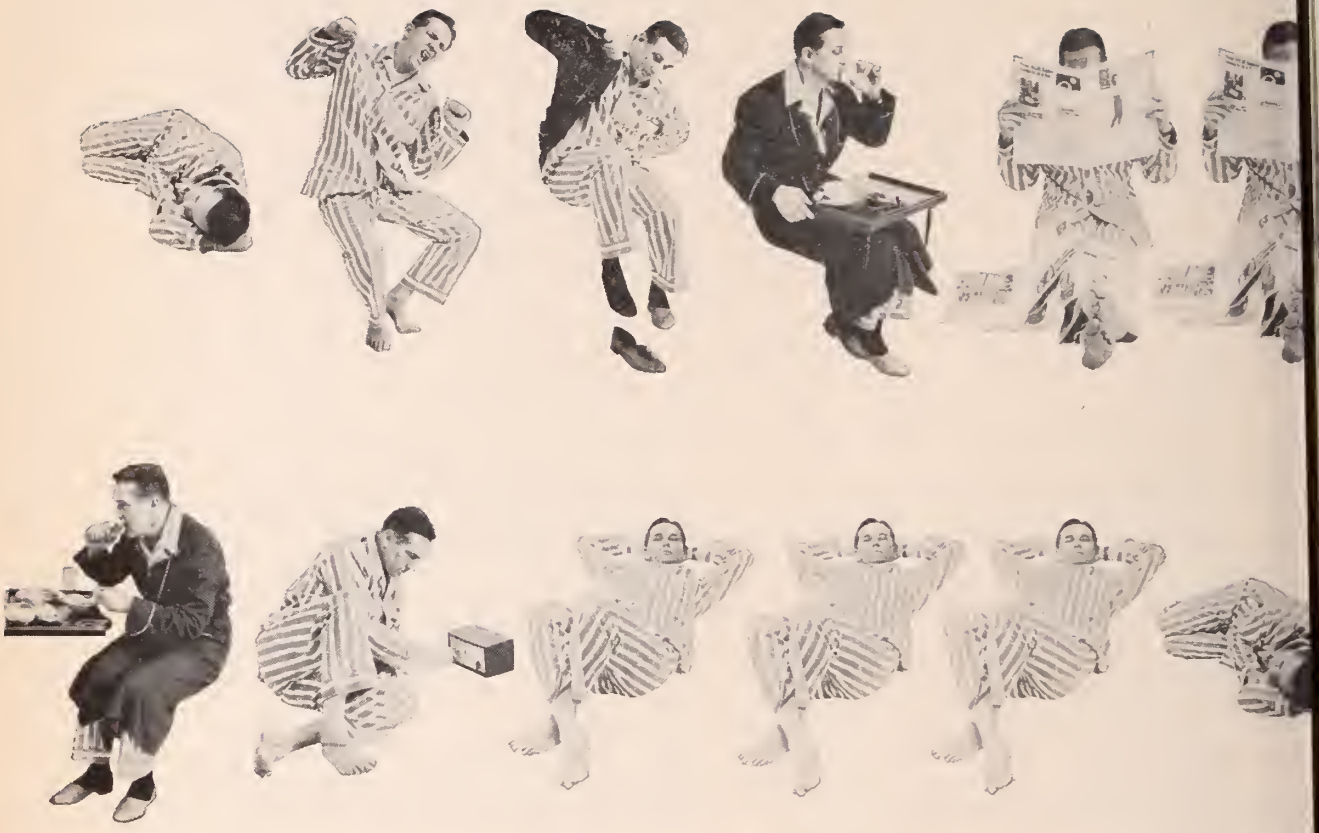
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Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
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10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.



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CONTENTS—Pages 41 to 94

EDITORIALS— Page

Cities Are Healthier ... 41
A Votre Sante ... 42

ORIGINAL ARTICLES—

Community Mobility and Emotional Disorder—Richard E. Gordon, M.D. and Katherine K. Gordon, B.S., Englewood, N. J. ... 43

Complications of Mesenteric Cysts—Elmer N. Mattioli, M.D., Vineland, N. J. ... 49

Gynecologic Aspects of Bleeding Factors—Hammell P. Shipps, M.D., Camden, N. J. 55

Appraisal of Loss of Visual Efficiency After Eye Injury—A. Russell Sherman, M.D., Newark, N. J. ... 60

Steroids in the Treatment of Childhood Tuberculosis—Arthur Heyman, M.D. and Edward Levitzky, M.D., Newark, N. J. 62

ORIGINAL ARTICLES— Page

Cerebral Angiography in the Management of Stroke—Robert A. Kuhn, M.D., Morristown, N. J. ... 68

Urologic Aspects of Hypertension—John J. Murphy, M.D., Philadelphia, Pa. ... 76

HISTORICAL ARTICLE—

Essex County Pathologic and Anatomic Society: The First Fifty Years—Samuel Berg, M.D., Newark, N. J. ... 81

ANNOUNCEMENTS ... 85
Services to Blind ... 54
What State Hospital for your Patient? ... 85

MARGINALIA OF MEDICINE ... 86

COUNTY SOCIETY REPORTS ... 87

BOOK REVIEWS ... 90

NTA ABSTRACTS ... 93

Roster of Officers and Committee Chairmen, Advertising Page 3A

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Fourth District (Camden, Burlington, Ocean and Monmouth Counties) — Daniel F. Featherston, Asbury Park (1960)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) — Isaac N. Patterson, Westville (1959)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) — Asbury Park
William F. Costello (1959) — Dover
Aldrich C. Crowe (1959) — Ocean City
J. Wallace Hurff (1960) — Newark
L. Samuel Sica (1960) — Trenton
Elmer P. Weigel (1960) — Plainfield

Alternates

Ralph M. L. Buchanan (1960) — Phillipsburg
Samuel M. Diskan (1959) — Atlantic City
Elton W. Lance (1959) — Rahway
Jesse McCall (1960) — Newton
Herschel Pettit (1960) — Ocean City
John H. Rowland (1960) — New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1959) — Dover
Connecticut—Lloyd A. Hamilton (1959) — Lambertville
New York—Levi M. Walker (1959) — Atlantic City
Connecticut—S. Eugene Dalton (1959) — Ventnor

1958 - 1959 COMMITTEE CHAIRMEN

Annual Meeting — Jerome G. Kaufman, Newark
Cancer Control — Asher Yaguda, Newark
Child Health — Robert E. Jennings, South Orange
Chronically Ill and Aging — William H. Hahn, Newark
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Workmen's Compensation — Andrew C. Ruoff,* Union City

*Deceased

1 Ladeez and gentlemen:
learn all about new VITERRA PEDIATRIC,
a good supplement
in a great new package.

2 First,
see what happens when
you push the metered plunger.

3 Aha!
An exact 0.6 cc.
comes out this spout.
Never more, never less.

4 And notice –
no drip, no waste,
no sticky bottle.

5 On your right,
see the Metered-Flow
bottle's tight seal.
No risk of
contamination.

6 Let's take a minute
to admire the formula.

7 *That* means
no hot-weather
loss of potency.

8 Now for a farewell treat, a taste of delicious, orange-y VITERRA PEDIATRIC. How will you have it – in fruit juice? On cereal? Straight from the spoon?

VITERRA® PEDIATRIC

each 0.6 cc. contains:

		M D R Infants	Children
A (synthetic)	5000 U S.P. Units	333%	167%
D (Calciferol)	1000 U S.P. Units	250%	250%
B_1 (Thiamine)	1 mg.	400%	133%
B_2 (Riboflavin)	1 mg.	167%	110%
B_6 (Pyridoxine)	1 mg	††	††
B_{12} (Cyanocobalamin)	1 mcg.	††	††
C (Ascorbic Acid)	50 mg.	500%	250%
Niacinamide	10 mg.	200%	133%
Panthenol	2 mg.		

In a d-sorbitol base for better vitamin B_{12} absorption

††Minimum daily requirement has not been established.

DOSAGE: 0.6 cc or as directed by physician.

In 50 cc. bottles

no refrigeration needed

VITERRA® PEDIATRIC

METERED-FLOW BOTTLE

ALLOW 30 SECONDS BETWEEN DISPENSINGS

Special note to doctors who took this tour:

Problems of over- and under-dosage, spillage, spoilage or leakage disappear with VITERRA PEDIATRIC'S new Metered-Flow bottle. Why not consider these advantages when you recommend a vitamin supplement?

Rx Pfizer

New York 17, N.Y.
Division, Chas. Pfizer & Co., Inc.
Science for the world's well-being



in vaginitis

TRICOFURON® IMPROVED

destroys all **3** *principal pathogens*

Whether vaginitis is caused by Trichomonas, Monilia or Hemophilus vaginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, the *established* specific trichomonacide FUROXONE® brand of furazolidone and the *combined* actions of both against Hemophilus vaginalis.

1. *Office* insufflation once weekly of the Powder (MICOFUR [*anti*-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued *home* use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).

Rx NEW BOX OF 24 SUPPOSITORIES WITH APPLICATOR FOR MORE PRACTICAL AND ECONOMICAL THERAPY.

NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides.

EATON LABORATORIES, NORWICH, NEW YORK


for
CERTAINTY
against
the
COCCI
Erythrocin®
stearate
(Erythromycin Stearate, Abbott)
an uncommon antibiotic for common infections

after millions of prescriptions

...an unparalleled safety record

provides fast, high blood and tissue concentrations

Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes. High, peak levels occur between one and two hours—and effective concentrations are maintained for at least six hours. Always at hand, then, against more critical infections is ERYTHROCIN-I.M.—the only intramuscular form of erythromycin available.

backed by years of clinical effectiveness

Actually, every prescription you write for ERYTHROCIN is backed by more than six years of clinical effectiveness against coccal infections. And, with the problem of antibiotic resistance becoming more important daily, the value of ERYTHROCIN as a day-to-day anticoccal agent is dramatically underlined.

supported by an unparalleled safety record

During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad-spectrum" action, the normal flora of the intestinal tract is virtually unaltered with ERYTHROCIN therapy.

offers bactericidal activity

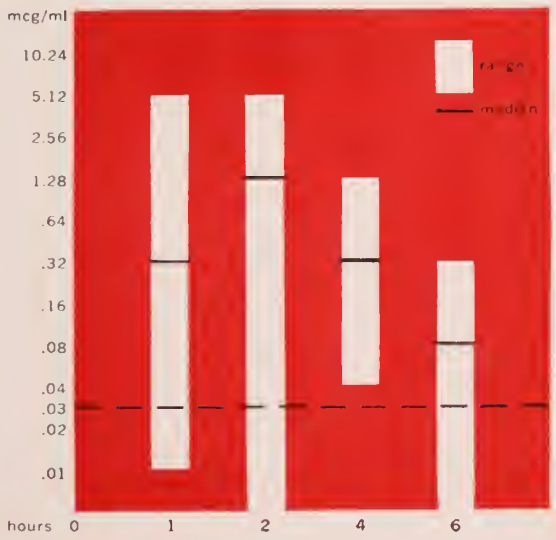
Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal antibiotic. It offers lethal action against common coccic invaders—resulting in prompt clinical response.

provides convenient dosage forms

Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also in oral suspension and for intramuscular use. Won't you prescribe ERYTHROCIN, doctor? Abbott

if you're concerned with blood levels...

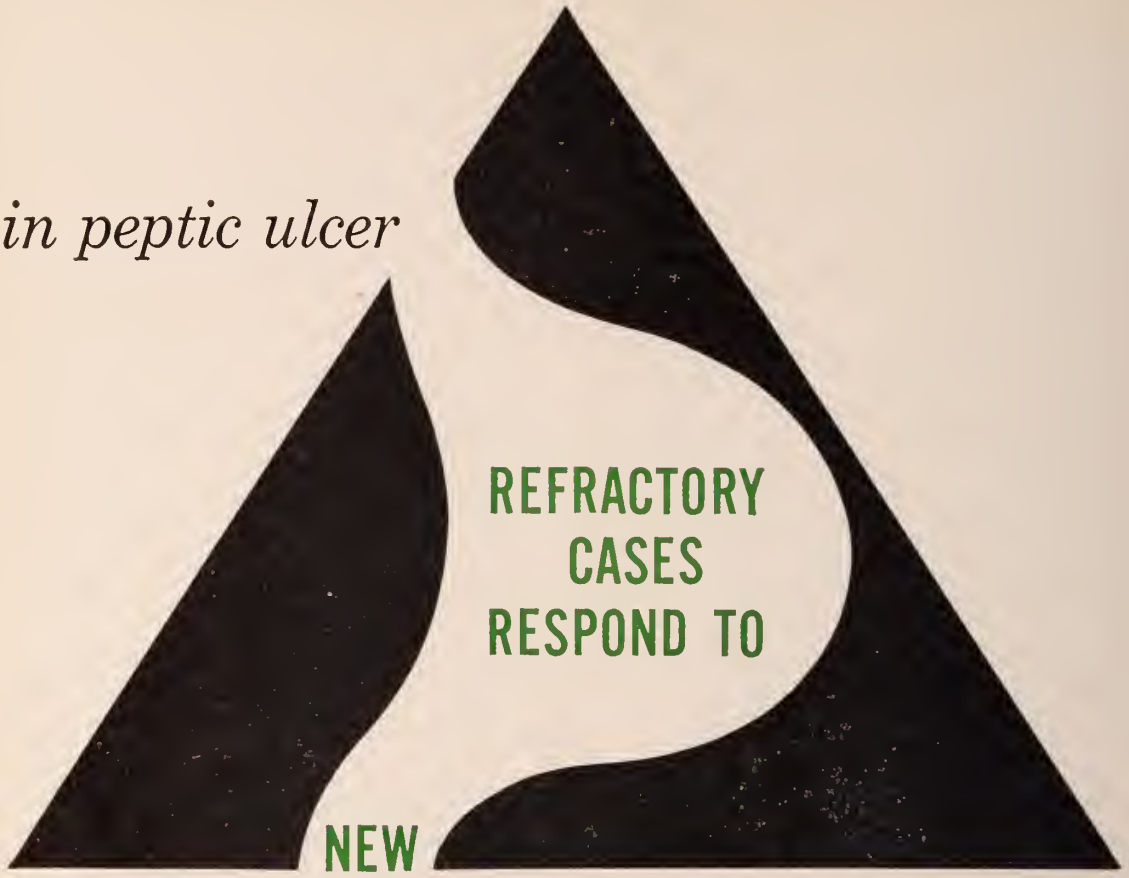
Dotted line shows actual inhibitory concentrations against most organisms. Note the high ranges and medians of ERYTHROCIN Stearate at one, two, four and six hours. Data represents three studies with adults. Each was given one 250-mg. Filmtab.



And where you need a consistent uniform response that only an injectable form can provide, remember—**ERYTHROCIN-I.M.**(Erythromycin Ethyl Succinate, Abbott) and **ERYTHROCIN LACTOBIONATE.**

®Filmtab—Film-scaled tablets, Abbott; pat. applied for.

in peptic ulcer



NEW

DARICON* *tablets*

OXYPHENCYCLIMINE HYDROCHLORIDE

POTENT ANTICHOLINERGIC ACTION

curbs secretion when excessive
normalizes motility when overactive

Activity appears to be restricted to the desired site of action.
Predictable therapeutic response in refractory cases.

Potency and Prolonged Duration of Action
10 mg. b.i.d. Average Dose · Supplied as:
10 mg. white, scored tablets

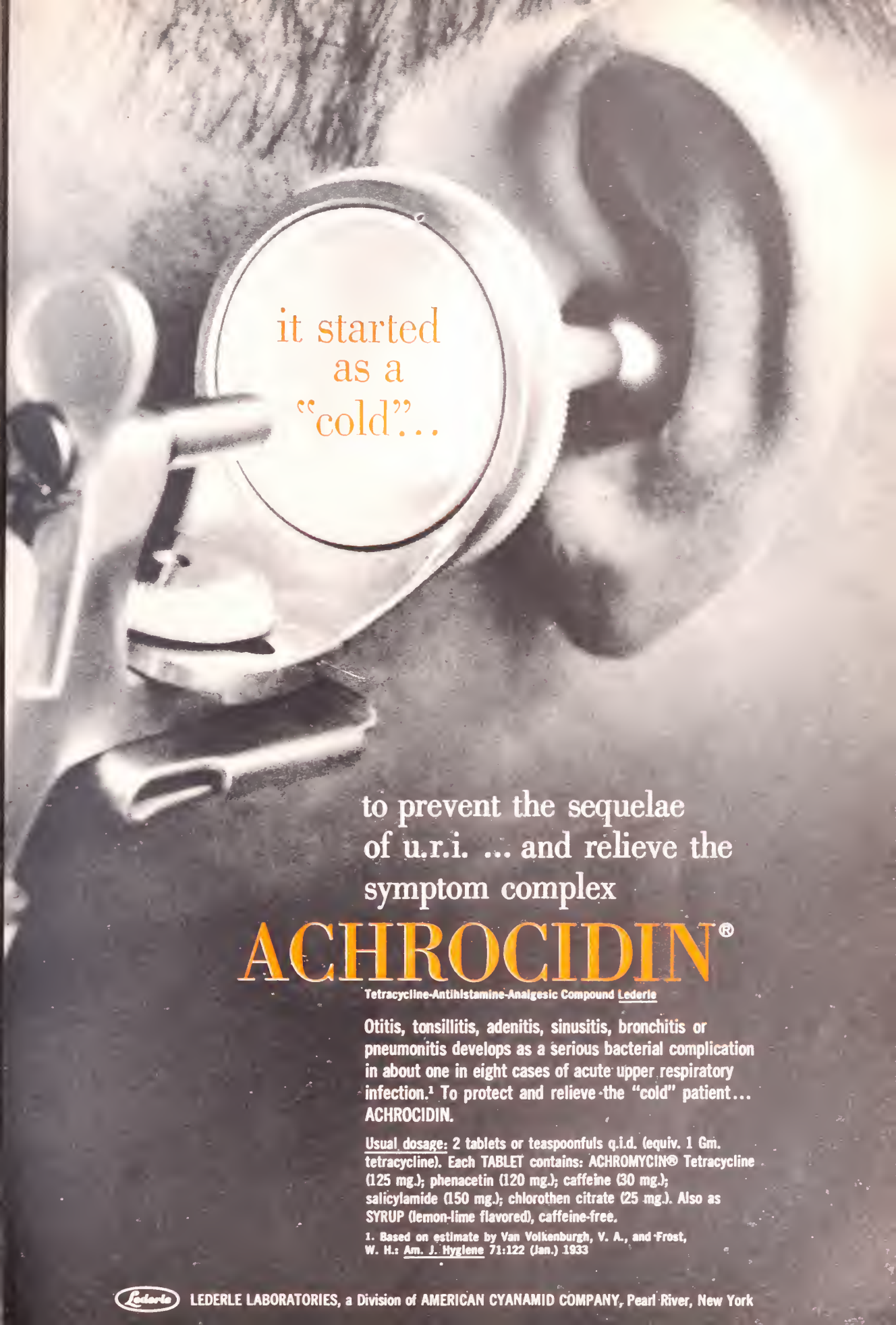
References: 1. Finkelstein, Murray: Journal of Pharmacology and Experimental Therapeutics, in press. 2. Winkelstein, Asher: Paper in preparation.

*Trademark

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.,
Brooklyn 6, N. Y.





to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Otitis, tonsillitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

IN OFFICE SURGERY

ELECTIVE AND TRAUMATIC

use XYLOCAINE *first...*
as a local anesthetic
or a topical anesthetic

SWAB SPRAY INFILTRATION NERVE BLOCK



Xylocaine HCl solution, the versatile anesthetic for general office surgery, relieves pain promptly and effectively with adequate duration of anesthesia. It is safe and predictable. Local tissue reactions and systemic side effects are rare. Supplied in 20 cc. and 50 cc. vials; 0.5%, 1% and 2% without epinephrine and with epinephrine 1:100,000; also in 2 cc. ampules; 2% without epinephrine and with epinephrine 1:100,000.

XYLOCAINE® HCl SOLUTION
(brand of lidocaine*)

Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

PDR

*U.S. PAT. NO 2,441,498 MADE IN U.S.A.

More effective clinically

in LOW BACK PAIN

TORTICOLLIS

BURSITIS and

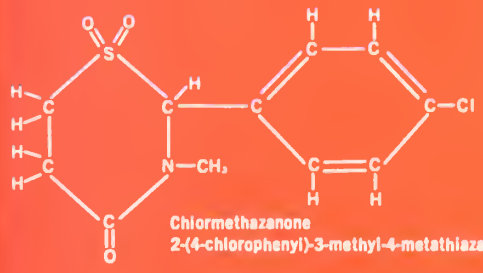
ANXIETY STATES

Trancopal

the first true tranquilaxant

MUSCLE RELAXANT

and TRANQUILIZER



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Unrelated chemically to any other therapeutic agent in current use. Better tolerated and safer than older drugs.

for clinical results in 4092 patients

see inside

Trancopal

the first true
*TRANQUILAXANT**

MUSCLE RELAXANT and TRANQUILIZER

clinical results in 4092 patients[5]

***tran-qui-lax-ant** (tran'kwi-lak'sant)
[< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

Clinical Comments

"We have just started using it [Trancopal] for relaxing spastic musculature and are *very much encouraged.*"[1]

Baker, University of Minnesota Medical School

"Chlormethazanone [Trancopal] not only relieved *painful muscle spasm*, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

Lichtman, New York Polyclinic Medical School and Hospital

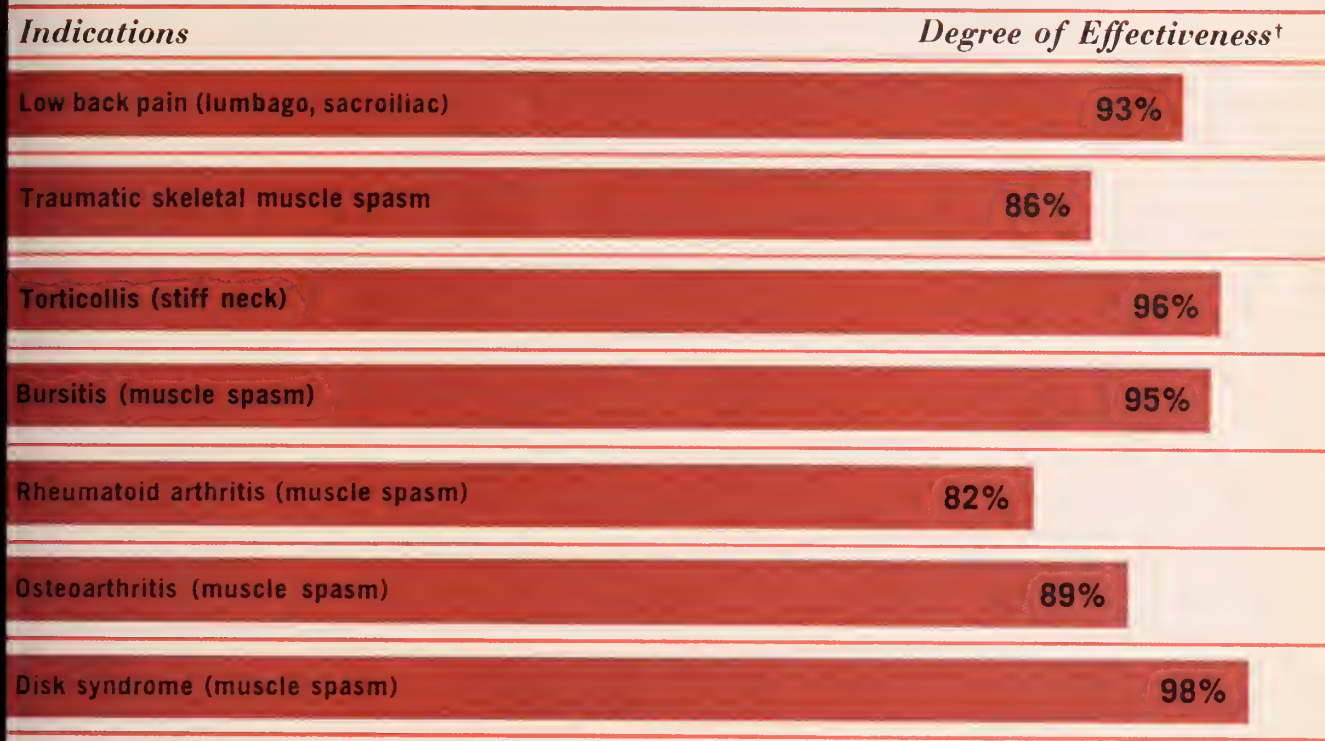
"The effect of this preparation in these cases [skeletal muscle spasm] was *excellent and prompt . . .*"[3]

Mullin and Epifano, Long Island College Hospital

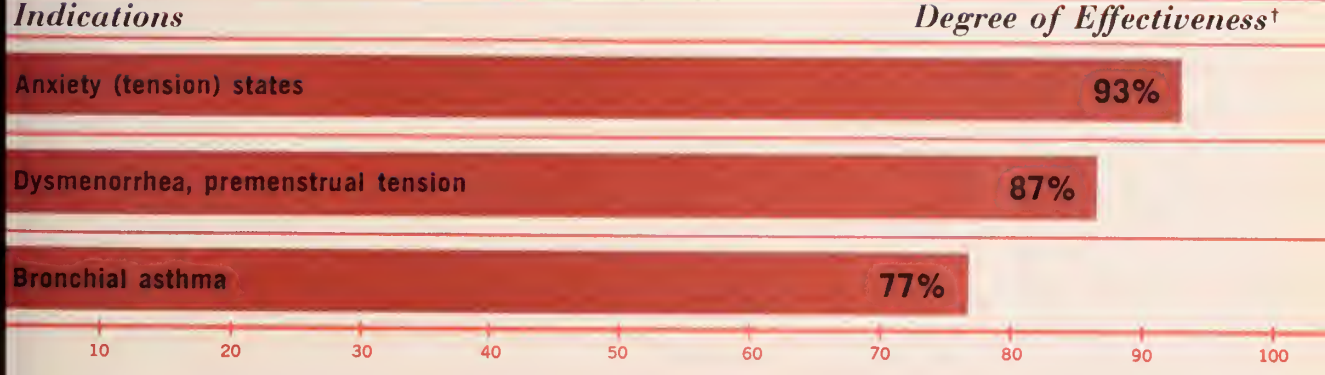
"In 120 patients with *anxiety or tension states,* 114 received satisfactory control of their condition. *Severe dysmenorrhea* and *premenstrual tension* in 65 patients refractory to the usual medications were relieved satisfactorily in 56."[4]

Lichtman

91% Effective in Musculoskeletal Disorders



89% Effective in Psychogenic Disorders



The results of clinical studies of over 4092 patients by 105 physicians demonstrate that Trancopal often is effective when other drugs have failed. From these studies it is clear that Trancopal probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other pharmaceutical agent in current use.

†*Excellent, good and fair*

Dosage:
Usual adult dose, 1 Caplet (100 mg.) three or four times daily. Children (from 5 to 12 years), ½ Caplet (50 mg.) three or four times daily.

Supplied:
Trancopal Caplets® (peach colored, scored) 100 mg., bottles of 100 and 1000.



Winthrop

Trancopal

the first true tranquilaxant

MUSCLE RELAXANT and TRANQUILIZER

ADVANTAGES OF TRANCOPAL

- Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.
- No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- Low toxicity. "As safe as aspirin."
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.
- No perceptible soporific effect, even in high dosage.

INDICATIONS

Musculoskeletal

Low back pain (lumbago)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disk syndrome
Fibrositis
Joint disorders (ankle sprain, tennis elbow, etc.)
Myositis
Postoperative myalgias

Psychogenic

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris

Neurologic

Muscle spasm (in paralysis agitans, multiple sclerosis, hemiplegia, cerebral palsy)

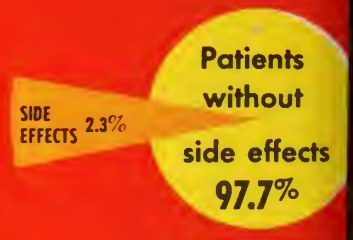
SAFETY

"As Safe As Aspirin"

$$\text{Safety Ratio} = \frac{LD_{50} \text{ in Mice}}{\text{Usual Human Dose}}$$



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4262 PATIENTS.

SUPPLIED

Trancopal Caplets (peach colored, scored) 100 mg., bottles of 100 and 1000.

REFERENCES

1. Baker, A. B.: Drugs to relieve increased tonus, spasticity, and rigidity of muscles, Modern Med. 26:140, April 15, 1958. • 2. Lichtman, A. L.: New developments in muscle relaxant therapy, Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • 3. Mullin, W. G. and Epifano, Leonard: To be published. • 4. Lichtman, A. L.: To be published. • 5. Cooperative Study, Department of Medical Research, Winthrop Laboratories.

Winthrop Laboratories • New York 18, N. Y.

Trancopal (brand of chlormethazanone) and Caplets, trademarks reg. U. S. Pat. Off. Printed in U. S. A. (406 I)

Now- All cold symptoms can be controlled



Provides Triaminic for more complete and more effective relief from nasal and paranasal congestion because of systemic transport to *all* respiratory membranes—without drawbacks of topical therapy.†

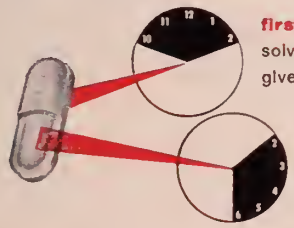
Provides well-tolerated APAP (N-acetyl-p-aminophenol) for prompt and effective analgesic and antipyretic action to make the patient more comfortable.

Provides Dormethan (brand of dextromethorphan HBr) for non-narcotic antitussive action on the cough reflex center in the medulla—as effective as codeine but without codeine's drawbacks.

Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

Special "timed release" design



first—the outer layer dissolves within minutes to give 3 to 4 hours of relief

then—the inner core releases its ingredients to sustain relief for 3 to 4 more hours

also available for those patients who prefer liquid medication: **Tussagesic suspension**

Each TUSSAGESIC tablet provides:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.
pheniramine maleate	12.5 mg.
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if needed.

Tussagesic* *timed-release tablets*

Contains* **TRIAMINIC *to* STOP *running noses and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada



MEDICINE IN ANCIENT EGYPT—one of a series of oil paintings, "A History of Medicine in Pictures," commissioned by Parke Davis.

Medicine's priceless past is but prologue to its brilliant present and future. To help provide a better public understanding and awareness of Medicine's proud traditions, Parke-Davis will launch a unique and informative new institutional advertising campaign this month. GREAT MOMENTS IN MEDICINE will depict historically accurate scenes of advancements in Medicine through the centuries. This very colorful and interesting Parke-Davis campaign will appear regularly during 1959 in LIFE, SATURDAY EVENING POST, TIME, READER'S DIGEST, and TODAY'S HEALTH. As a preview to the medical profession, the first ad in this series is reprinted above. Within a few weeks millions of people throughout the United States—and the world—will also see it.

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Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

PROFESSIONAL LIABILITY PROTECTION

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in corticosteroid therapy of allergic diseases asthma-hay fever allergic rhinitis allergic dermatitis drug reactions



Decadron*

DEXAMETHASONE

to treat more patients more effectively

a new order of magnitude in therapeutic effectiveness
a new order of magnitude in margin of safety

Excellent and good-to-excellent results are reported[1] with DECADRON in nearly all of 362 patients with various allergic disorders, including a number of cases who had failed to respond to other corticosteroids. No major reactions were observed in these extensive clinical studies even after four months of continuous therapy—DECADRON produced no peptic ulcer, no diabetes, no significant hypertension, no sodium retention, no potassium depletion, no edema, no undesirable psychic reactions, and no unusual or new side effects. Less than five per cent of patients experienced minor reactions, none of which prevented continuing administration of DECADRON.

Moreover, several investigators report that side effects induced by previous corticosteroid therapy such as gastric intolerance, peripheral edema, headache, vertigo, muscle weakness, ecchymoses, flushing, sweating, moon facies, hypertension, hirsutism, and acne often disappeared during therapy with DECADRON. Analysis of clinical reports

Dosage: One 0.75 mg tablet of DECADRON will replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg tablet of cortisone

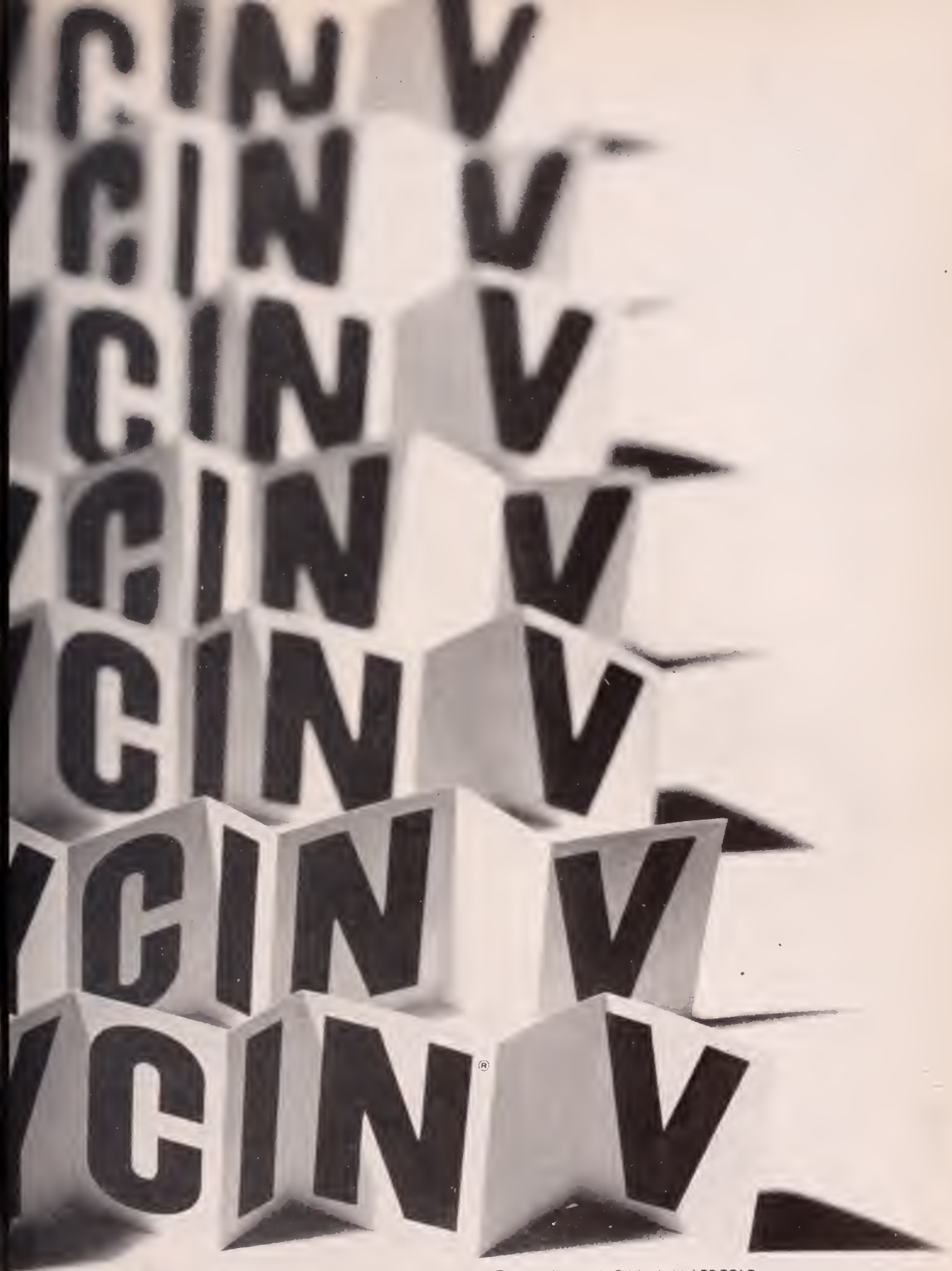
Detailed information on dosage and precautions is available to physicians on request.

Supplied: As 0.75 and 0.5 mg scored, pentagon-shaped tablets in bottles of 100.

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Tetracycline with Citric Acid *LEDERLE*

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for

OTITIS EXTERNA
FURUNCULOSIS
OTOMYCOSIS
OTITIS MEDIA

Otamylon® and Otamylon® with Hydrocortisone

EAR DROPS

BACTERICIDAL
FUNGICIDAL
ANALGESIC
HYGROSCOPIC

Manner of Use:

After gently cleansing and drying the ear canal, Otamylon (2 or 3 drops or moistened wick) is applied three or four times daily.

Supplied:

Otamylon—bottles (15 cc.) with dropper.
Otamylon c̄ Hydrocortisone—15 cc. combination package to be mixed prior to dispensing.

Otamylon is a clear, odorless, sterile, viscid liquid containing:
Sulfamylon® HCl 5%
Benzocaine 5%
Anhydrous glycol q.s. 100

Otamylon with Hydrocortisone:
Same formula with 0.02% hydrocortisone.

Winthrop LABORATORIES
New York 18, N.Y.

Otamylon and Sulfamylon (brand of mafenide), trademarks reg. U. S. Pat. Off.

Restore G. I. harmony promptly—in virtually all diarrheas—with

DONNAGEL®

Robins

or

DONNAGEL® with NEOMYCIN

These comprehensive formulae provide adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic, as may be desired. For prompt and more dependable control of virtually all diarrheas.

ONNAGEL: In each 30 cc. (1 fl. oz.):

aolin (90 gr.)	6.0 Gm.
ectin (2 gr.)	142.8 mg.
lyoscyamine sulfate	0.1037 mg.
tropine sulfate	0.0194 mg.
lyoscine hydrobromide	0.0065 mg.
henobarbital (¼ gr.)	16.2 mg.

ONNAGEL WITH NEOMYCIN:

ame formula, plus
leomycin sulfate ..... 300 mg.
(Equal to neomycin base, 210 mg.)

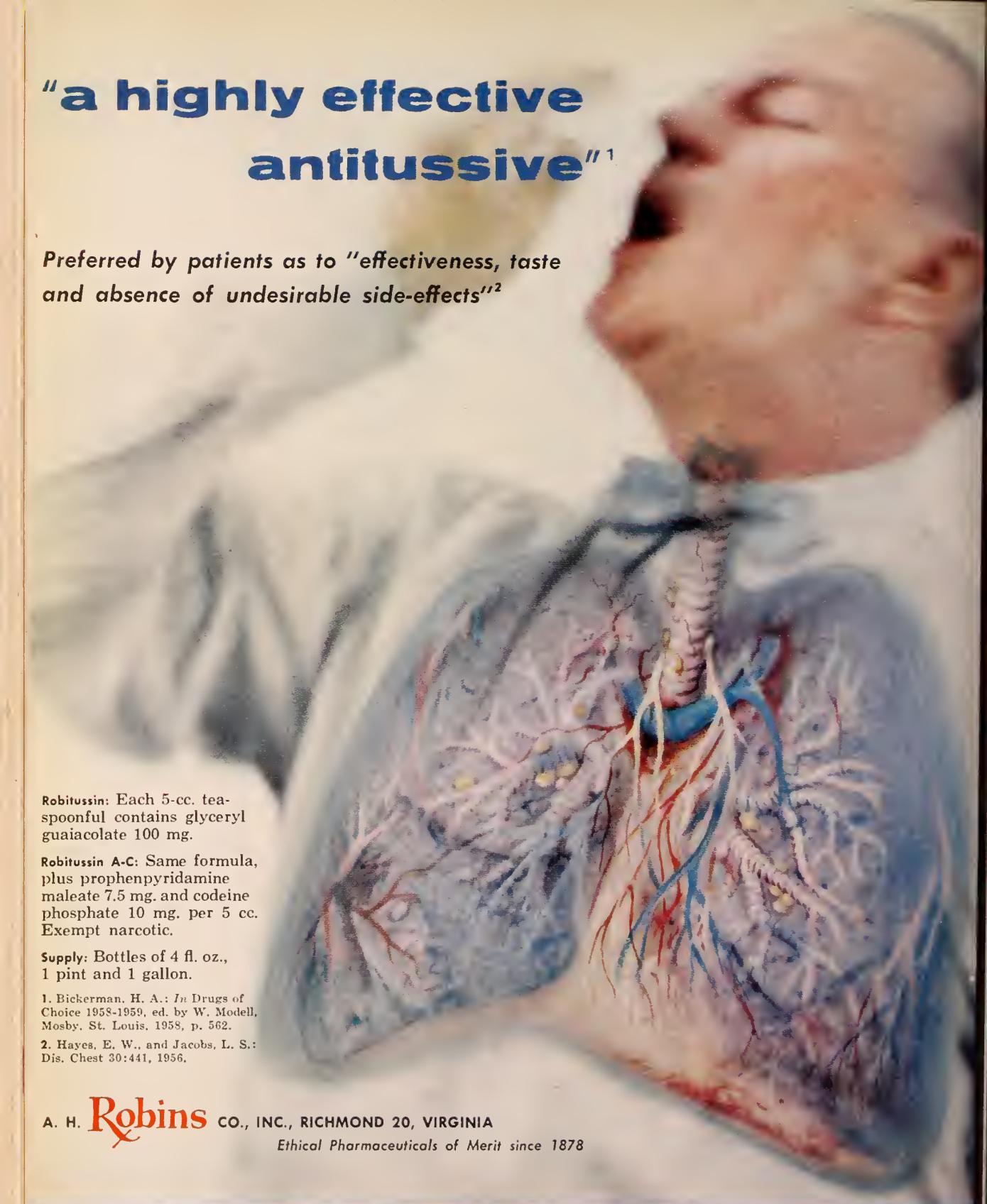
A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA
Ethical Pharmaceuticals of Merit Since 1878

...for all ages...in all seasons



"a highly effective antitussive"[1]

Preferred by patients as to "effectiveness, taste and absence of undesirable side-effects"[2]



Robitussin: Each 5-cc. teaspoonful contains glyceryl guaiacolate 100 mg.

Robitussin A-C: Same formula, plus prophenpyridamine maleate 7.5 mg. and codeine phosphate 10 mg. per 5 cc. Exempt narcotic.

Supply: Bottles of 4 fl. oz., 1 pint and 1 gallon.

1. Bickerman, H. A.: *In* Drugs of Choice 1958-1959, ed. by W. Modell, Mosby, St. Louis, 1958, p. 562.

2. Hayes, E. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956.

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Ethical Pharmaceuticals of Merit since 1878

Robitussin® or Robitussin® A-C

Robins

ROBITUSSIN WITH ANTIHISTAMINE AND CODEINE

Established Standard Therapy in Hypertension*

Rauwiloid®

alseroxylon, 2 mg.



just two tablets at bedtime

After full effect one tablet suffices

*Because

Rauwiloid provides effective Rauwolfia action virtually free from side effects... the smooth therapeutic efficacy of Rauwiloid is associated with significantly less toxicity than reserpine... and with a lower incidence of depression. Tolerance does not develop.

Rauwiloid is initial therapy for every hypertensive patient. ...Dosage adjustment is never a problem...

•

When more potent drugs are needed, prescribe one of the *convenient single-tablet combinations*

Rauwiloid® + Veriloid®
alseroxylon 1 mg. and alkavervir 3 mg.

or

Rauwiloid® + Hexamethonium
alseroxylon 1 mg. and hexamethonium chloride dihydrate 250 mg.

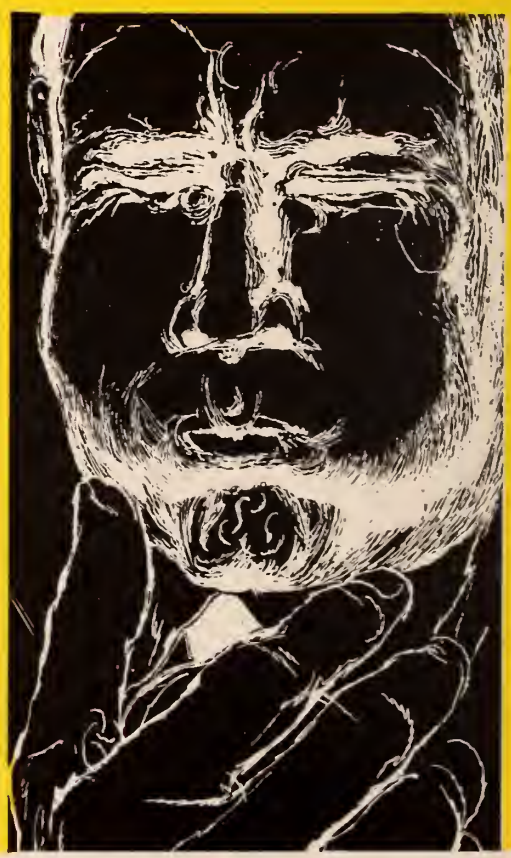
Many patients with severe hypertension can be maintained on Rauwiloid alone after desired blood pressure levels are reached with combination medication.

Northridge, California

the higher
blood levels of
potassium
penicillin V

Compoc

FOR
THOSE
COMMON
BACTERIAL
PROBLEMS



902069

IN FILMTAB® / IN ORAL SOLUTION

AND IN COMBINATION WITH SULFAS

illin®-VK

(POTASSIUM PENICILLIN V)

INDICATIONS

Against all penicillin-sensitive organisms. When combined with Sulfas, COMPOCILLIN-VK is especially effective in treating mixed infections such as may occur in the respiratory or urinary tract.

DOSAGE

Range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. Children's dosage is determined by body weight. When combined with sulfa triad, range is one Filmtab three times daily to two Filmtabs every four hours.

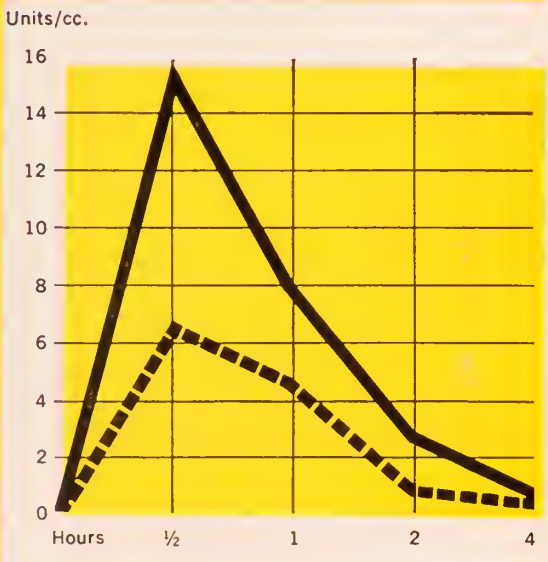
SUPPLIED

COMPOCILLIN-VK Filmtabs: 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100.

COMPOCILLIN-VK Granules for Oral Solution: In 40-cc. and 80-cc. bottles. When reconstituted, each tasty 5-cc. teaspoonful of cherry-flavored solution represents 125 mg. (200,000 units) of potassium penicillin V.

COMPOCILLIN-VK with Sulfas: Each Filmtab contains 125 mg. (200,000 units) of potassium penicillin V and 500 mg. of sulfonamides. At all pharmacies.

Abbott



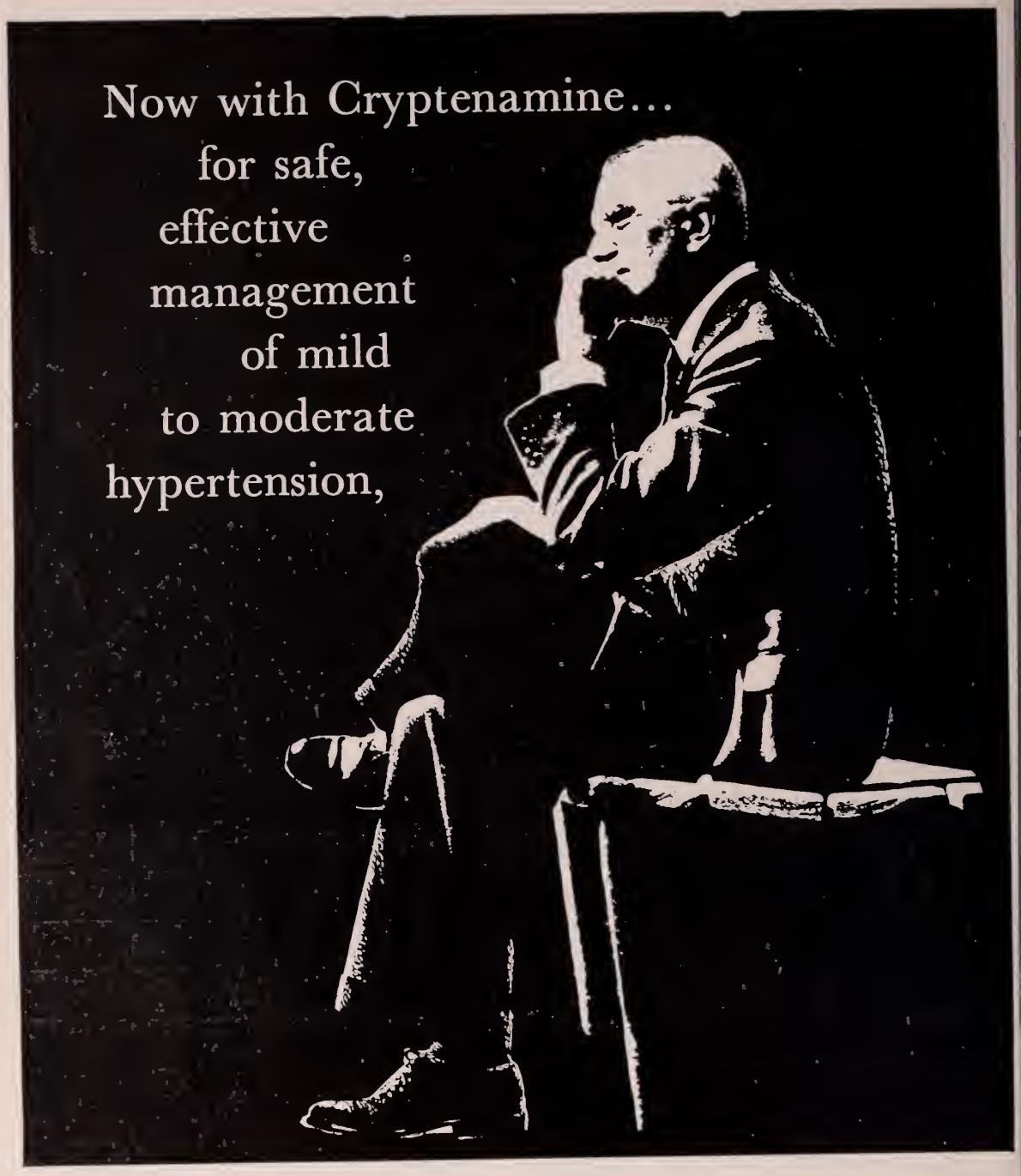
The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

®FILMTAB—FILM-SEALED TABLETS, ABBOTT. PAT. APPLIED FOR.



℞ Veratrite®

Prescribed with confidence 8,863,769 times Veratrite continues to be the antihypertensive of choice for treating geriatric patients.

Veratrite effectively reduces blood pressure through action on the sympathetic nervous system, without detriment to the cardiac output.

Each VERATRITE tabule contains:

Cryptenamine (tannates) 40 C.S.R.*	Units
Sodium nitrite	1 gr.
Phenobarbital	¼ gr.

*Carotid Sinus Reflex

IRWIN, NEISLER & CO. • DECATUR, ILLINOIS

Neisler



JUST 1 TABLET DAILY

WHENEVER SULFAS ARE INDICATED

KYNEX*

Sulfamethoxypyridazine Lederle

provides therapeutic sulfa levels for 24 hours... Highly soluble... rapidly absorbed... produces fast, sustained plasma-tissue concentrations. Simple, easy-to-remember, single 0.5 Gm. daily dose. No crystalluria. [1]

with low incidence of sensitivity reactions... Extremely low in toxic potential. [2,3] No cutaneous or other objective reactions seen in a wide scale study of clinical toxicity. [2] Even minor subjective reactions are not expected to occur [2] or are reported absent [3] when recommended schedule is used.

TABLETS, 0.5 Gm., bottles of 24 and 100. New ACETYL PEDIATRIC SUSPENSION, cherry flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.), bottles of 4 and 16 fl. oz.

1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

*Reg. U.S. Pat. Off.

Lederle

UNIQUE VITAMIN SUPPLEMENT

NEW VIGRAN CHEWABLES

SQUIBB MULTIPLE VITAMIN SOFT TABLETS

fruit-punch flavored tablets that will actually "melt in the mouth"



can be chewed like candy



can be crushed and sprinkled on cereal or other food



can be dissolved in water, juice or milk



can be sucked and will dissolve like a lozenge



can be easily swallowed (small tablet size)

VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth.* Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good.* These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B_1, B_2, niacinamide and C, and significant amounts of other essential vitamins.

Each VIGRAN CHEWABLE tablet contains:

Vitamin A	5,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin C	75 mg.
Vitamin B_1	3 mg.
Vitamin B_2	3 mg.
Vitamin B_6	2 mg.
Niacinamide	25 mg.
Calcium Pantothenate	3 mg.
Vitamin B_{12}	5 mcg.

Available in Rx-size bottles of 30 and 90.

SQUIBB

Squibb Quality—the Priceless Ingredient

'Vigran'® is a Squibb trademark

for depression

▲Deprol▲†

Clinically confirmed in over 2,500 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation

► restores natural sleep

► reduces depressive rumination and crying

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function

► causes no excessive elation

► produces no liver toxicity

► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†TRADE MARK

CD-7469

Literature and samples on request ® WALLACE LABORATORIES, *New Brunswick, N.J.*

Until the discovery of DECADRON* by MERCK SHARP & DOHME, when your diabetic patients were also in need of corticosteroid treatment, you were often faced with a difficult therapeutic dilemma. Diabetes mellitus was a recognized contraindication to the use of corticosteroids, since they not only aggravated the existing diabetic symptoms, but often precipitated latent diabetes.

NOW EVEN many diabetic patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

DECADRON—the new and most potent of all anti-inflammatory corticosteroids—**is** remarkable for its **virtual absence of diabetogenic effect** in therapeutic doses.



Decadron*

DEXAMETHASONE

to treat more patients more effectively

In clinical trials with some 1,500 patients glycosuria was noted in only two, transitory glycosuria in another two, and flattening of the glucose tolerance curve in one. There were no instances of aggravation of existing diabetes, no increase in insulin requirements. Patients whose diabetes was severely aggravated on prednisolone showed good tolerance when transferred to DECADRON.

MORE patients can be treated with DECADRON than with other corticosteroids, because in addition to being practically free of diabetogenic activity, therapy with DECADRON is also practically free of sodium retention, potassium depletion, hypertension, edema and psychic disturbances. Cushingoid effects are fewer and milder. DECADRON has not caused any new or "peculiar" reactions, and has produced neither euphoria nor depression, but helps restore a "natural" sense of well-being.

*DECADRON is a trademark of Merck & Co., Inc., ©1958 Merck & Co., Inc.

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

'TABLOID'

'EMPIRIN' COMPOUND®

WITH

CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations

Symbols OF PROVEN PAIN RELIEF



gr. 1



gr. ½



gr. ¼



gr. ⅛

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Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

'CODEMPIRAL'® NO. 3*



Codeine Phosphate . . . . . gr. ½
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

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Codeine Phosphate . . . . . gr. ¼
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

..from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

'TABLOID'

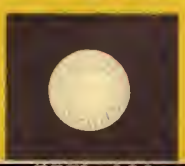
'EMPIRIN' COMPOUND®



Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½
Caffeine . . . . . gr. ½

..from mild pain complicated by tension and restlessness.

'EMPIRAL'®



Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

*Subject to Federal Narcotic Regulations

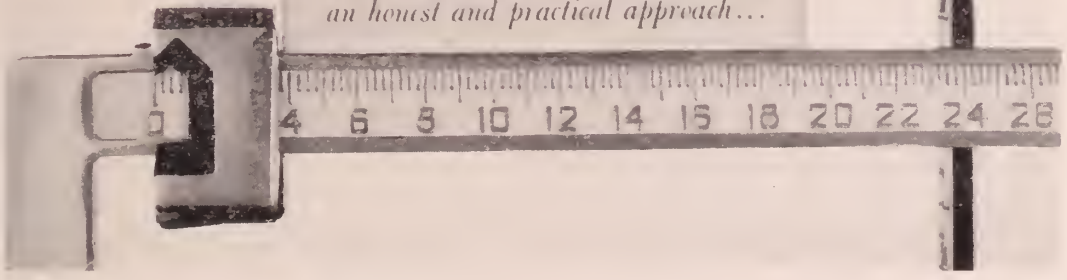
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Based on latest medically accepted information—in a simple, inviting format which the layman will find easy to follow. Contents include authentic height-weight charts . . . clear explanation of calories . . . basic meal patterns . . . key role of yogurt in dieting and many other facts.



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"finger-itis"

there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. . . assured anti-inflammatory effect of low-dosage corticosteroid[1]

. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

. . . wide range of applic
including the entire
fibrositis syndrome
as well as early or m
rheumatoid arthritis

**more manageable
corticosteroid dos**

. . . much less likelihood
of treatment-interru
side effects[1-6]

. . . simple, flexible dosage schedule



in any case
it calls for

Sigmagen®

corticoid-salicylate compound

tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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60-J-649

Schering

conditions: Two or three
four times daily. After
response is obtained,
lly reduce daily dosage
en discontinue.

ute or chronic conditions:
y as above. When satisfactory
is obtained, gradually reduce
ly dosage to minimum
ve maintenance level. For best
administer after meals and
time.

utions: Because SIGMAGEN
ns prednisone, the
precautions and
indications observed
is steroid apply also
use of SIGMAGEN.

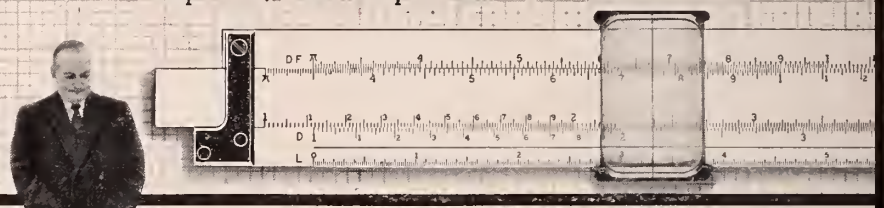
℞ PRONOUNCED TAY-O

Tao*

(triacetyloleandomycin)

Capsules / Oral Suspension

designed for superior control of common Gram-positi infections

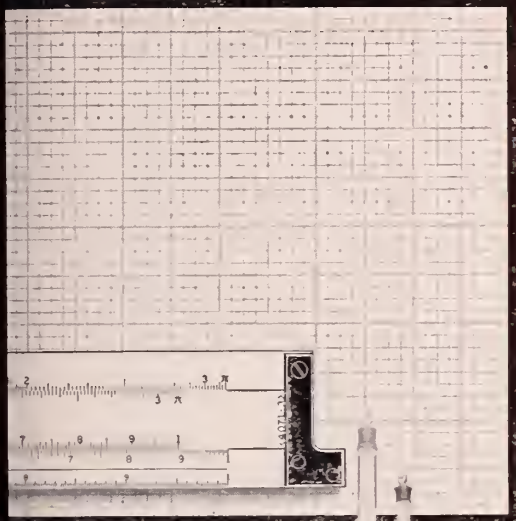




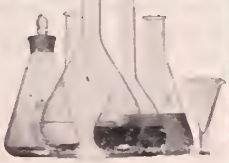
in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failur
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	**19**	**3**	6
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

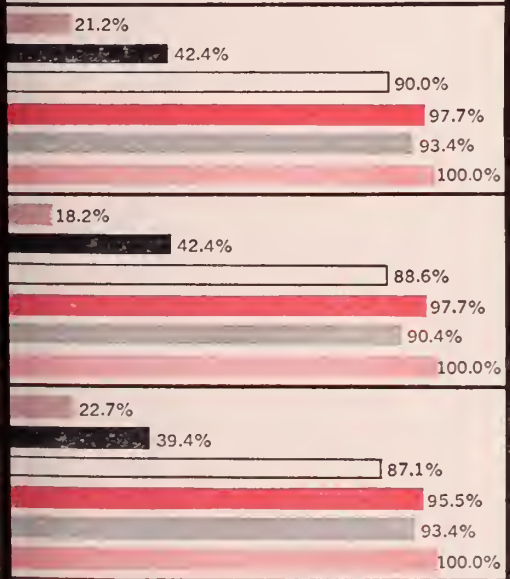


the
boratory:



r 90% effective
inst resistant staph

PARATIVE TESTS BY THREE METHODS
, TUBE DILUTION, CYLINDER PLATE)
30 STAPHYLOCOCCI[9]



tibiotic A 2-10 units — Tao 2-15 mcg.
tibiotic B 5-30 mcg. — Antibiotic D 2-15 mcg.
tibiotic C 5-30 mcg. — Antibiotic E 5-30 mcg.

ntage of organisms inhibited by the range of
ntrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed – stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity – freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable – "practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules – 250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension – 1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

Tao dosage forms – for specific clinical situations

Tao Pediatric Drops

For children – flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers – 5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

TAO-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action – in clinical emergencies.

Supplied: In 10 cc. vials.

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How can the problem of "postcholecystectomy syndrome" be reduced?

A "routine" operative cholangiogram is now recommended in addition to thorough surgical exploration, reducing the number of cholecystectomized patients later presenting the same symptoms as before the operation.

Source: Vazquez, S. G.: J. Internat. Coll. Surgeons *28*:394, 1957.

for pre- and postoperative management of biliary tract disorders... **DECHOLIN**® *"therapeutic bile"*

*Hydro*choleresis with DECHOLIN combats bile stasis by flushing the biliary tract with dilute, natural bile...

- corrects excessive bile concentration
- helps to thin gallbladder contents
- benefits patients with chronic cholecystitis, noncalculous cholangitis, and biliary dyskinesia

in functional G.I. distress... **DECHOLIN**® **with BELLADONNA**

- reliable spasmolysis
- improved liver function

available: DECHOLIN Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.). Bottles of 100, 500 and 1,000; drums of 5,000.

DECHOLIN with Belladonna Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.) and extract of belladonna ⅙ gr. (10 mg.). Bottles of 100 and 500.

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AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

A workhorse "mycin" for common infections



respiratory infections

prompt, high blood levels

consistently reliable and reproducible blood levels

minimal adverse reactions

With well-tolerated CYCLAMYCIN, you will find it possible to control many common infections rapidly and to do so with remarkable freedom from untoward reactions. CYCLAMYCIN is indicated in numerous bacterial invasions of the respiratory system—lobar pneumonia, bronchopneumonia, tracheitis, bronchitis, and other acute infections. It has been proved effective against a wide range of organisms, such as pneumococci, H. influenzae, streptococci, and many strains of staphylococci, including some resistant to other "mycins." Supplied as Capsules, 125 and 250 mg., vials of 36; Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.

new

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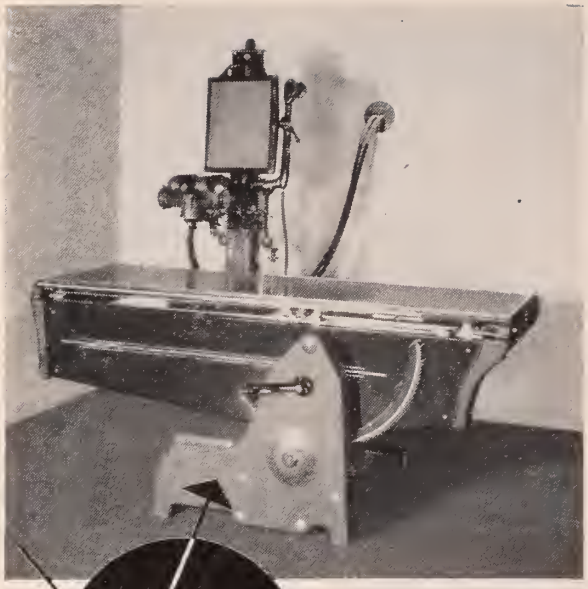
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Here's the perfect answer for a cost-saving x-ray installation, easy to keep abreast of important new developments. G-E Maxiservice ties up *none* of your capital . . . eliminates trade-in losses — progress determines your time for exchange, not finances. In effect, you contract for *utility, convenience, flexibility* and *service,* not for just equipment.

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83% MAJOR
(Grade I and II)
IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL®** or Aralen® as maintenance the With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therap are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

Write for Booklet.

In the Treatment of Rheumatic Disorders Greater stability of maintenance dosage minimizes risks of hormonal imbalance

In Sterazolidin, the anti-inflammatory actions of prednisone and Butazolidin* are combined to permit lower effective dosage of each. Clinical experience has indicated that patients can be well maintained on this combination over prolonged periods with relatively low, stable dosage levels of each component, thus minimizing the problems arising from excessively high doses of corticosteroids. Other side effects have also been gratifyingly few. Antacid and spasmolytic components are contained in Sterazolidin capsules for the benefit of patients with gastric sensitivity.

Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

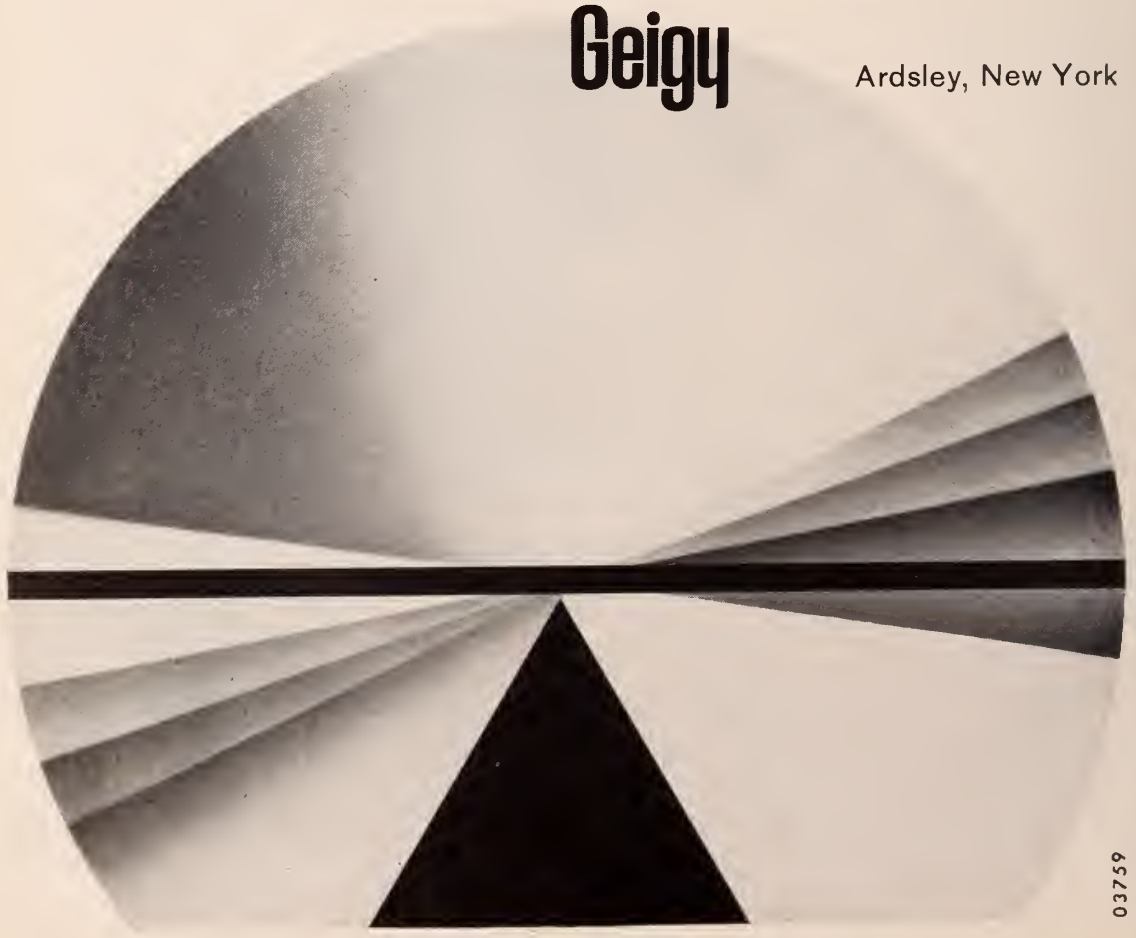
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running noses and open stuffed noses orally



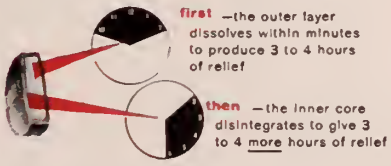
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- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . . 50 mg.
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One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

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RATIONALE

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Reinhardt, D. J.:
Delaware State Med. J. **30**:1, January 1958.

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"We have presented a group of 48 patients previously treated with a variety of antihypertensive agents." "Upon the addition of chlorothiazide to their regimens, there was realized an additional blood pressure lowering effect of 23 mm. systolic and 11 mm. diastolic."

Bunn, W. H., Jr.:
Ohio State Med. J. **54**:1168, September 1958.

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"There is an extremely wide range between therapeutic and toxic dosage, and no significant side effects and no sensitivity to the drug as yet have been observed."
". . . it seems desirable to add potassium chloride 4 Gm. per day . . . in cases of hypertension. . . ."

Herrmann, G. R., Hejtmancik, M. R., Graham, R. N. and Marburger, R. C.:
Texas State J. Med. **54**:639, September 1958.

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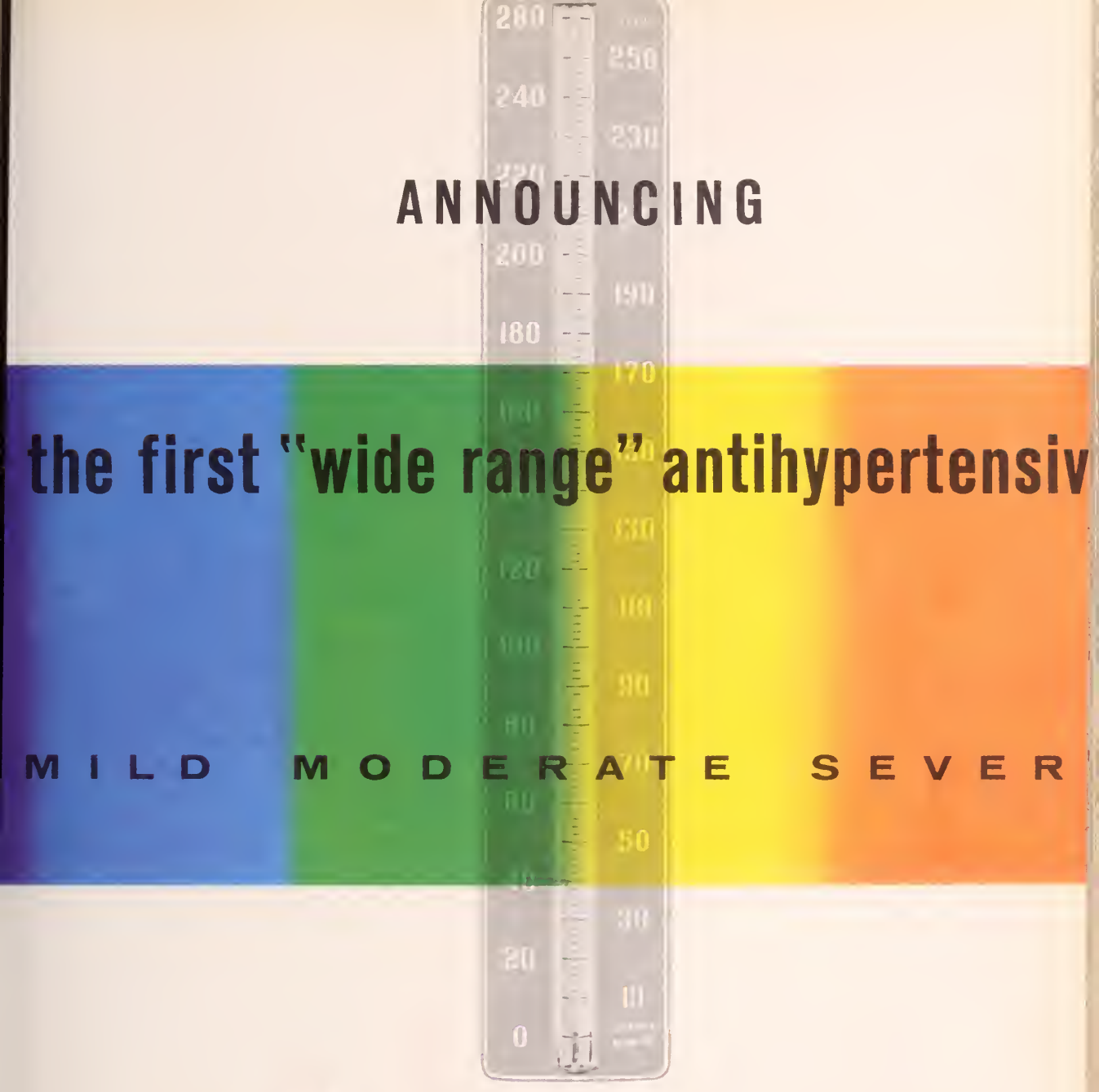
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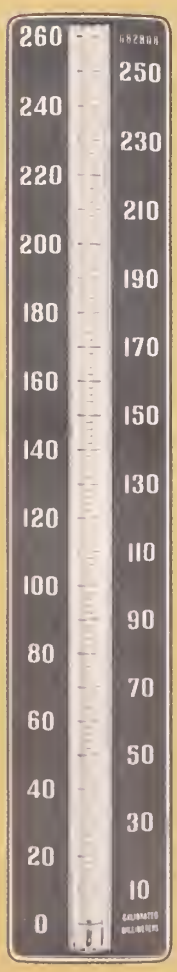
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. . . with greater simplicity and convenience

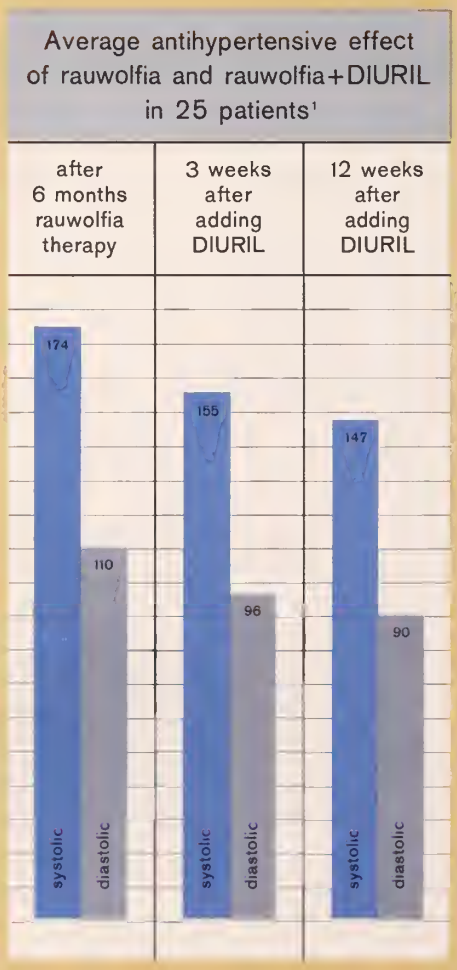
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you know and trust provides

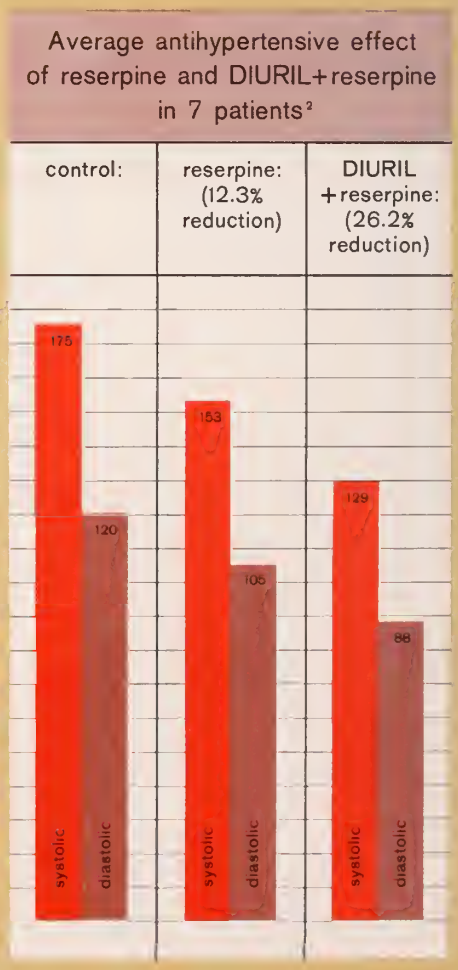
increased effectiveness, decreased side effects

potentiated effect

DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.







DIUPRES

DIURIL® WITH RESERPINE

effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet provided this gives approximately the correct dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

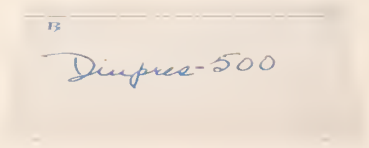
- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

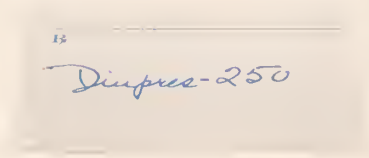
Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.
If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.



DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

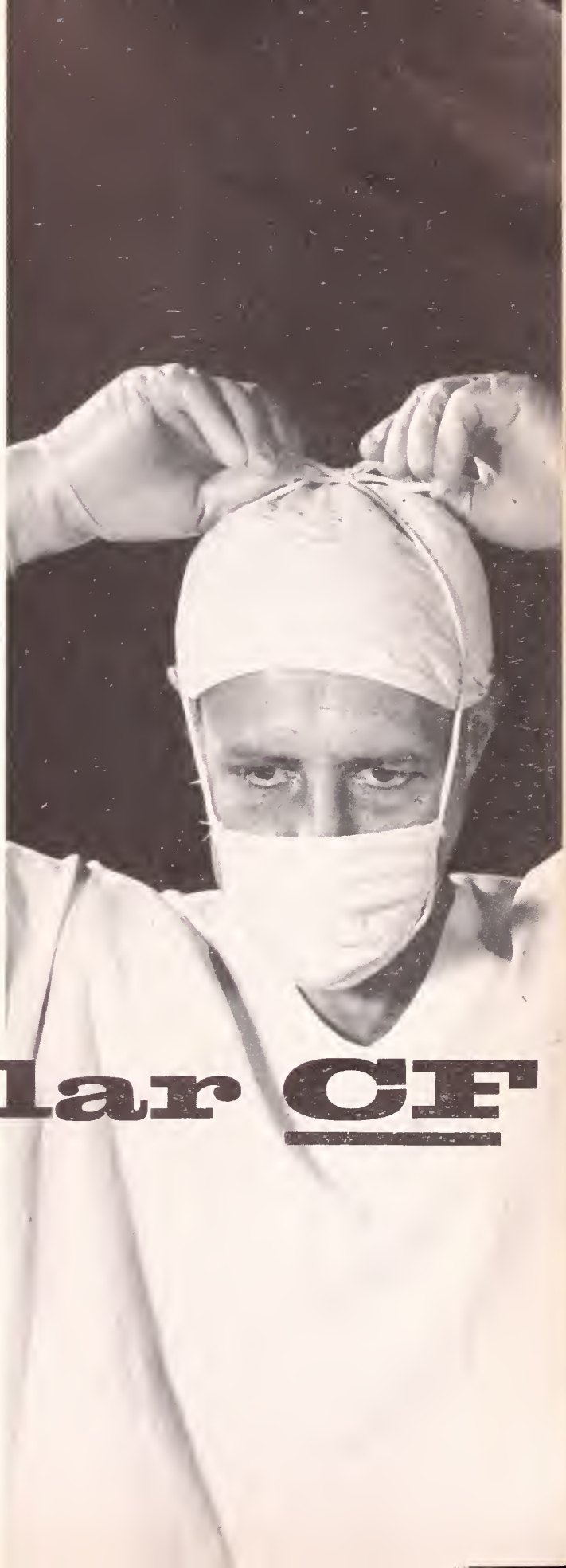
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MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

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Romilar Cold Formula controls the entire symptomatology of colds, including coughs. A synergistic combination,* Romilar CF

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suppresses coughing
relieves congestion
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this surgeon takes Romilar CF

Each teaspoonful (5 cc) of pleasantly flavored syrup, or each capsule, contains: 15 mg Romilar HBr (non-narcotic antitussive); 1.25 mg Chlorpheniramine maleate (antihistamine); 5 mg Phenylephrine HCl (decongestant); 120 mg N-acetyl-p-aminophenol (analgesic-antipyretic).

*L. O. Randall and J. Selitto, *J. Am. Pharm. Assn. (Sc. Ed.)*, 47:313, 1958.

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Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 30 micrograms of endogenous estradiol production in the menopausal woman: i.e., restores the "premenopausal prime."

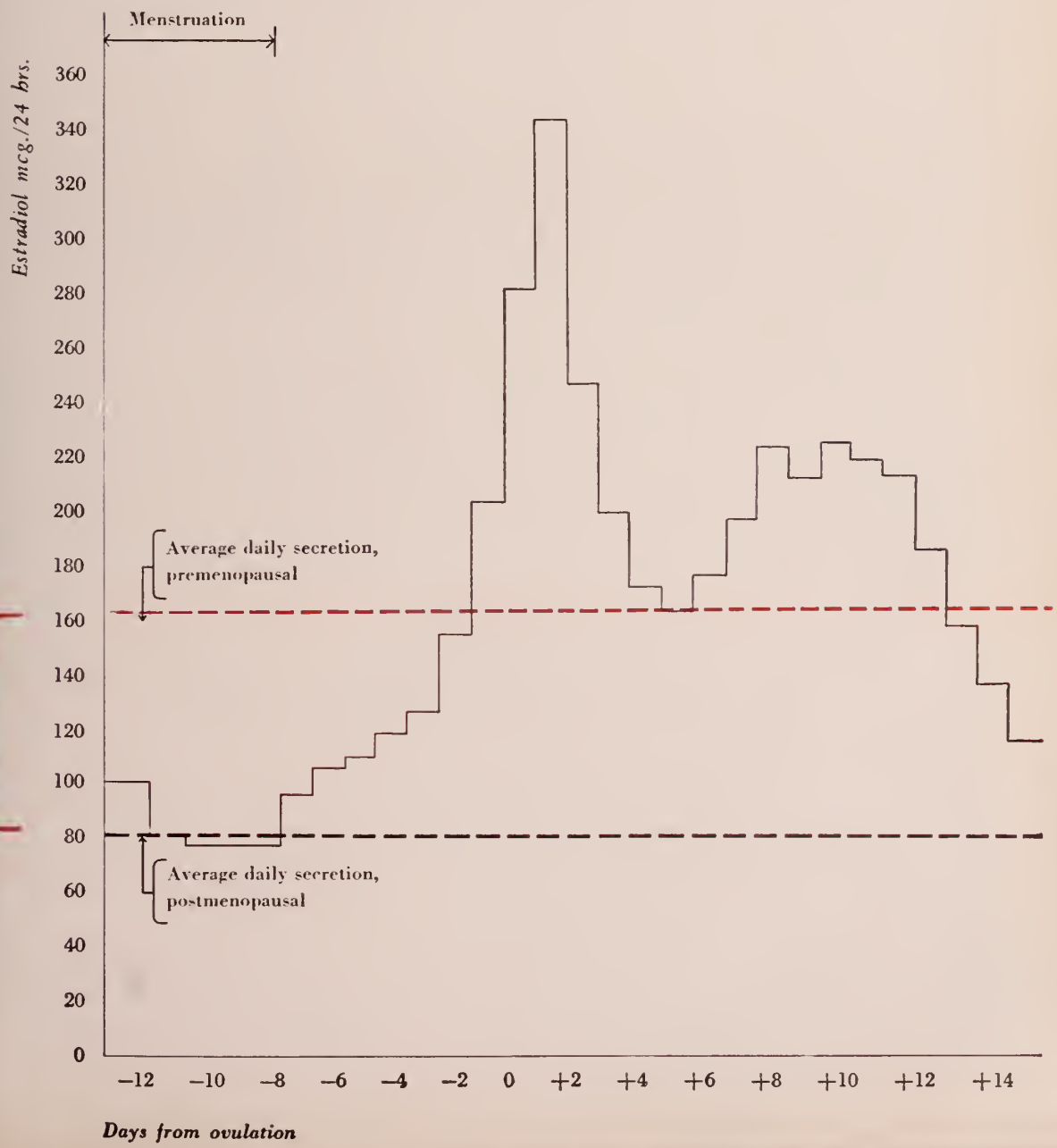
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action, so desirable in patients of advanced years.

Upjohn

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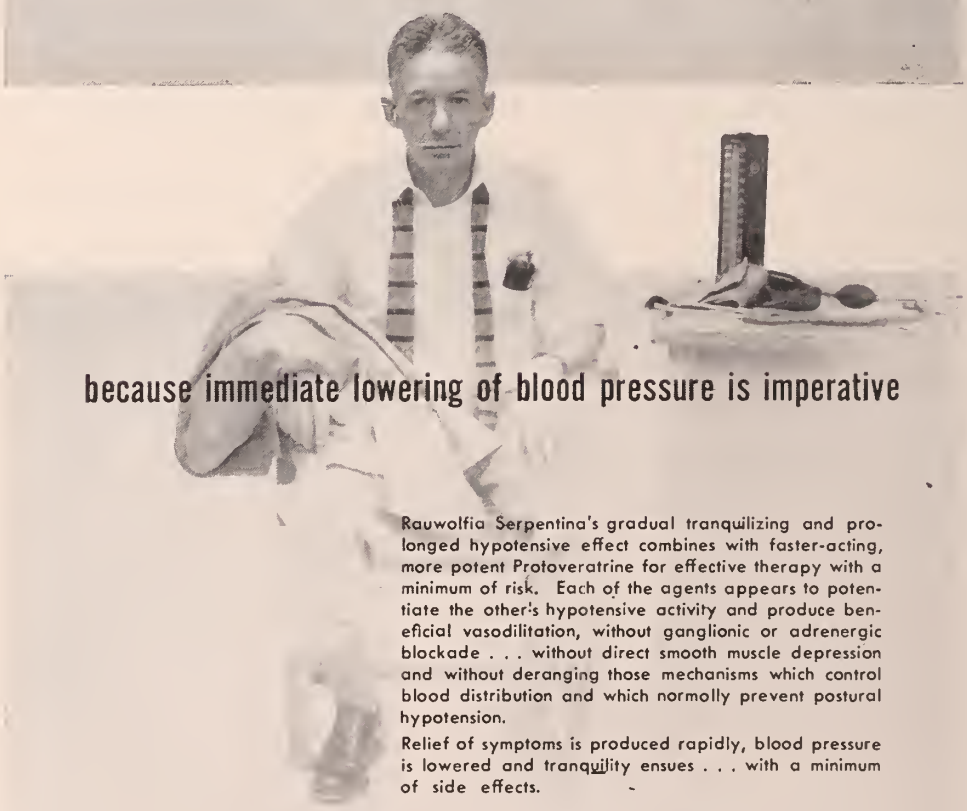
Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)



diagnosis: **hypertension, moderate to severe**

prescribed: **Rauprote***

(Rauwolfia Serpentina and Protoveratrines A & B Combined)



because immediate lowering of blood pressure is imperative

Rauwolfia Serpentina's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protoveratrine for effective therapy with a minimum of risk. Each of the agents appears to potentiate the other's hypotensive activity and produce beneficial vasodilitation, without ganglionic or adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which control blood distribution and which normolly prevent postural hypotension.

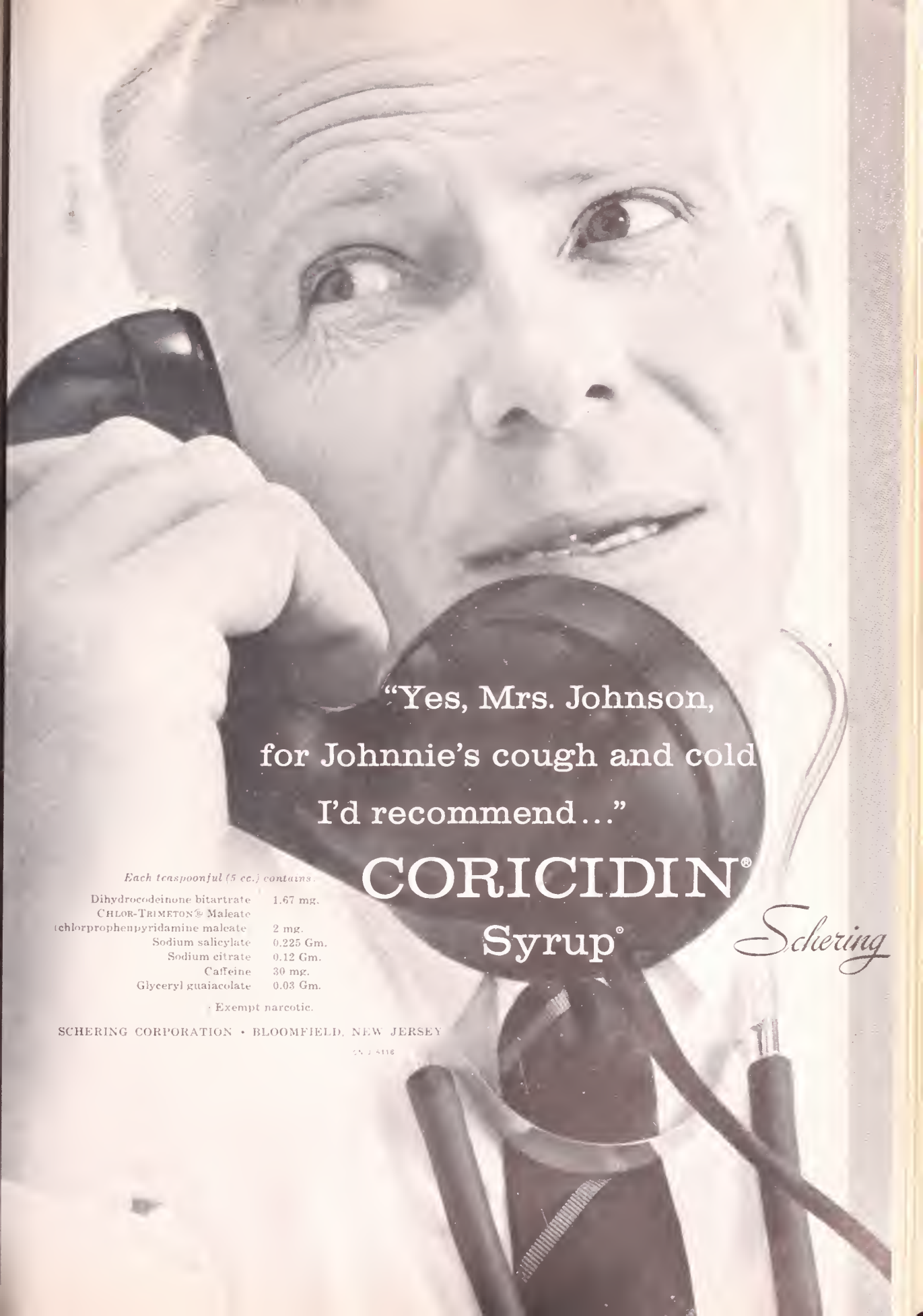
Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

supplied: in bottles of 100 and 1000 tablets, each containing 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (the chemically standardized alkaloid of Veratrum Alba), or on prescription at leading pharmacies

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Dihydrocodeinone bitartrate	1.67 mg.
CHLOR-TRIMETON® Maleate (chlorprophenpyridamine maleate)	2 mg.
Sodium salicylate	0.225 Gm.
Sodium citrate	0.12 Gm.
Caffeine	30 mg.
Glyceryl guaiacolate	0.03 Gm.

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THE JOURNAL
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Editorials • • •

Cities are Healthier

Traditionally the city was an unhealthy place, whereas rural areas were associated with rosy cheeks, robust health and long life. Until recently, the city's reputation for ill health was well deserved. The great plagues and pandemics that periodically swept the world were essentially urban phenomena. According to studies made by that ever-useful body, the Health Information Foundation, infant mortality in New York in 1915 was twice the figure for rural Minnesota, despite the greater availability of medical care in New York. Since cities are becoming increasingly more congested (try to find parking space if you don't believe it) one would suppose that urban areas would show rising death rates from disease.

However, that has not happened. Death rates have been tumbling in all parts of the country—but the improvement has been more conspicuous in urban places. Suburbs, exurbs and farm areas are getting more urban all the time, and death rates are getting closer together. Thus difference between the highest rate area and the best rate area was 32 per cent twenty years ago. Now the difference is only 15 per cent. The urban-rural division is becoming meaningless. The two areas with the highest mortality rates are the heavily urbanized New Jersey-New York-Pennsylvania district where the rate (per thousand) is 8.7; and the second highest is the predominantly rural Kentucky - Tennessee - Mississippi area where the rate is 8.4. By contrast, along the Pacific coast, the rate is only 7.6.

The best health and hospital facilities in the world are right in our own New York-New Jersey-Pennsylvania areas. And we also have the highest death rate in the country. This unenviable distinction is due entirely to two disorders: cardiovascular diseases and malignancy. We in this area have lower death rates than any other section in infectious diseases and accidents. Perhaps superior diagnostic facilities may send up the *recorded* death rate from cancer—a condition which might be misdiagnosed as an infectious death elsewhere.

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It is also possible that famous medical centers attract desperately ill people, thus sky-rocketting the reported death rates in well-resourced areas.

Nationally, there are 9 hospital beds per thousand population. In the east south central area there are only 7, whereas in our part of the country the figure is 12½. Analogous ratios are reported for physicians and nurses.

We are fast becoming one giant city. Living in a rural or small town area once implied a kind of pastoral idyl—gas lamps, pigs rooting in the backyard, a country store centered around a cracker barrel, and mail-order merchandise. Today a small town address, or even an R.D. number conjures the image of a concrete super-highway punctuated by modernistic shopping centers. Since the city is now everywhere, it is just as well that it is becoming healthier.

A Votre Sante

Elsewhere in this issue,* we publish a review of a new translation of a pioneer work by Claude Bernard. The new edition of this still readable volume* reminds us of the extraordinary role played by French scientists in the development of modern medicine. Start, if you will, with Ambroise Paré in the 16th century who discovered how to ligate vessels. Wait a century and add Rene Descartes whose very name has become an eponym for a psychologic method. Look then at French contributions in the extraordinary 19th century—Magendie and Laennec, Charcot and Janet, Claude Bernard and Louis Pasteur. Turn the century and note such names as Becquerel and Pierre Curie, Alexis Carrel and Alphonse Laveran. Add Albert Schweitzer and Pierre Denker (who introduced chlorpromazine), Elie Metchnikoff, and Charles Nicolle and you have a star-studded galaxy of solid contributors to the march of medicine.

Some of the names sound non-Gallic: Schweitzer, Denker and Metchnikoff, for instance. Yet they must be credited to the French Republic. Nobel prize winners include Moissan, Becquerel, Curie, Laveran, Metchnikoff, Cournand, Bovet, Carrell, Nicolle and Richet—a roster of ten Nobel laureates in five decades—an astonishing record for one country. One Frenchman gave us the stethoscope, another the prophylaxis of rabies. Radioactivity was discovered first in Paris, where two Frenchmen—Becquerel and Curie opened that Pandora's box. Phagocytosis was first presented in France. And here too was invented the alcohol-carrying thermometer (by Rene de Reaumur). In France the glycogenic function of the liver was discovered (by Claude Bernard). Modern psychiatry stems from the work of Jean Charcot and Pierre Janet; the former was Freud's first psychiatric teacher. Broca more than any one else worked out the enduring principles of cerebral localization. The hypodermic syringe is generally credited to Charles Pravaz, a Parisian orthopedist. Morphine, quinine and strychnine were originally isolated by Frenchmen (Seguin, Sertuerner and Pelletier). Trefouel, now head of the Pasteur Institute, was the first to isolate sulfanilamide, the axis of the sulfa drugs. Bovet's experiments in the early 1930s led to the discovery of antihistaminics.

France has given us more than French beans, French horns, French fried potatoes, and French pastry; more than salad dressings, doors, and French cuffs. France has given us a corps of scientists who have made it possible for medicine to take giant steps ahead. They have not, as a nation, been good at self promotion, so that these indispensable contributions have often been forgotten. But they have a right to look us all in the eye and pledge *A Votre Sante.*

* See page 91.

Richard E. Gordon, M.D.
Katherine K. Gordon, B.S.*
Englewood

Community Mobility and Emotional Disorder

One of the indictments of the physician is that he is so concerned about what's inside the individual patient that he does not raise his sights to see what's outside the patient. Dr. Gordon obviously need not plead guilty to that indictment. Here is an unusual presentation of medicine as a social science rather than a biologic one.

Social psychiatric studies have been reported recently about patients in Bergen County, New Jersey. The findings should be of general interest to medical practitioners in any metropolitan community or suburb. Detailed presentations of tables and data, bibliographical references, and calculations of statistical significance are available. This paper boils down the essential findings and conclusions to date of the several studies.[2,3,4,5,6]

This country has nurtured ambitious, pioneering, independent, rugged individualists who scorn dependence upon family, the past and tradition. Their striving to get ahead materially and socially has resulted in rapid industrial growth and unlimited opportunities. This spirit attracted continuing waves of immigrants to America. As they, their children, and grandchildren advance economically, go to college, and enter the American middle class, they seek new homes and a new way of life for themselves and their children in the suburbs.[9] In New Jersey, Bergen County's recent rapid growth has brought into sharp focus, and has magnified the effects of this suburban migration, its benefits, its strains and its hardships. Growth has been so fast that community members, services, and organizations sometimes become overloaded and disintegrated. The high incidence of emotional difficulties, psychosomatic disorders, and delinquency are undoubtedly related to the fast pace of life and rate of growth in the county. This paper will present some of these interrelations as they affect patients seen in medical practice. Physicians, perhaps, will better be able to help their patients as well as understand how to guide the community in preventing future similar problems.

The Young Married Man

He is an ambitious, industrious fellow. By getting more education, oftentimes in night school, than his first or second generation American parents, and working long hours, he has risen into the middle class and obtained a white collar, executive or professional position. He has married an "upwardly mobile" girl like himself, but often of different background and ethnic origin, bought a car and home on installments, moved from the city to Bergen County, and started a family. To maintain this new position (for which he has had little previous preparation or experience) he

*Dr. Gordon is Director of Research, Mental Health Unit, Englewood Hospital. Mrs. Gordon is Research Assistant, Englewood Hospital.

must continue to work long hours, commuting to the city, often having to travel on his job, which takes him away from home sometimes several days and even weeks at a time. He races from appointment to appointment. Bergen County's accident rate on the highways is the highest in New Jersey.

Previously from a city apartment, he must now adjust himself to learning how to maintain a home, lawn, garden and all the necessary equipment. No wonder with such a continual strain, he may show tension symptoms and psychosomatic disorders!

However he is usually not the main sufferer. He is not lonely for he has his friends at work and customers to see regularly. He is usually getting ahead. (When he is not getting ahead, he really begins to suffer.) He is doing what our culture has encouraged and rewards well for good performance.

HIS WIFE

Consider his wife for she has a bigger problem. She, too, was unprepared for suburban living. Her family also came from an apartment in the city. She has left her family behind, as well as her old friends. Her new neighbors are Americans of many different backgrounds, religious affiliations and origins. She may find it difficult to understand them and make friends of them.

Her education has prepared her, like her husband, for commercial work, not for homemaking and child-rearing. She studied geometry and physics in high school, not child care and cooking. Everyone is questioning exactly how to raise children. She heard that the old, strict methods are wrong. But now people are criticizing the more progressive methods. What is right? She is little rewarded for her efforts. No one hangs medals on her or writes her up in the newspapers for succeeding in weaning her baby or habit training her little boy. Our culture rewards accomplishments in business and industry, not in the home.

Her husband is so busy he has no time for her or the children. He is exhausted when he comes home. He just wants to put on his old clothes and relax with the evening paper. Maybe he has to paint the house or mow the lawn. She is bored, tense and lonesome. She wants him to take over the children and relieve her of the strain. She wants him to talk to her, discuss her problems and try to find some solutions. She wants to get away from the house, see some friends. But her husband is too tired.

In addition to his community-encouraged emphasis upon "getting ahead" he may come from a cultural background in which men's and women's roles were clearly separated. If so, he cannot understand, and often has little patience with her wishes. He cannot comprehend that his wife has little community support and recognition in her daily round, compared to his mother and grandmother; or that she may have considerably less personal interest in being a *hausfrau*, and has been prepared educationally more for the outside world of business than for home life.

So she is confused. She reads innumerable articles in women's magazines on how to enjoy suburban life, how to improve her marriage, how to raise children. Her women's club invites psychiatrists and psychologists to speak to them and give them the answers. She may develop guilt, depression, tension symptoms or psychosomatic complaints. She is suffering more than her husband. Our suburban psychiatric clinics and hospitals draw a large proportion of their patients from her group: the young married women with children. And when she collapses everyone suffers: husband, children and community at large. And there is no one to help her for she is away from her family and is not yet friendly with her neighbors. Her husband himself is operating under strain and has little reserve.

Divorced, widowed, and separated young women often have great difficulty finding a place in our family-oriented suburban community, especially if they have children. It is sometimes hard for them to develop and maintain proper social relationships. They have the problem of raising their sons without a husband's assistance. Fatherless boys are among our most difficult child patients. These women contribute disproportionately to our mental hospital population.

THE CHILDREN

All newcomers have a very difficult time, but the boys have the worst of it. Boys are to become men; yet they have few men in their early lives after whom to model their behavior. If the father is away all day, and has no energy or time to enter into games, play, discussion, or any type of father-son companionships, the son will suffer. The boy usually has no other man to guide and help him channel his masculine energies into useful outlets. Girls at least are with their mothers. They can play at house, or at cooking, or can care for dolls with an example before them and a guide to answer their questions. In Bergen County there are many women-organized cub scouts, but few troops for older boys led by men. This deficiency in male guidance, counseling and companionship may explain boys' slowness in school in the early years. A boy cannot model himself after his mother without inner conflict. And if he follows the older, uncontrolled boys he often gets into trouble. So the disturbance and delinquency rates among boys mount in our rapidly growing suburb.

THE MIDDLE AGED COUPLE

Let us take a look at the men and women in their late forties and fifties. This is the period of greatest success or failure in men. If they have made the grade they are less frequent candidates for psychiatric services. They are now able to afford to live comfortably, slow down the pace a bit, and learn to enjoy life. However, wear and tear have taken their toll. They often have irreversible organic changes from the psychosomatic disorders of their "struggle" period. They continue to worry about their wives and sons. And if they have not succeeded, they really have trouble. Now, in the period of physical decline, they realize that they will never accomplish their ambitions. The struggle, long hours, commuters' rush, have all been in vain. Their depression hits hard. The danger of suicide is greater here than in any other group.

Middle aged wives enter a readjustment period, too. The children are growing up and leaving home for college and marriage. Mother has done nothing but home and child care. In our mobile society her children will probably leave and move to another community. Her services are no longer required. She is out of a job, retired socially as well as physiologically, for this is the period of the menopause. She, too, may plunge into a severe depression.

SENIOR CITIZENS

People past sixty have their problems. Society has passed them by. Their children are gone. They cannot keep up with the changes in their neighborhood. They have not the stamina for a forty-hour work week at the pace the young people are setting. Many had grown up in a world in which the authority of grandfather and grandmother was powerful in the homes of adult children. Left alone, they often cannot adjust and may end up in nursing homes or state hospitals. If taken in to live with their children, they may try to run things. Psychiatrists see as many of the daughters and daughters-in-law who have the strains of caring for and trying to manage a home with grandmother trying to dominate it as they see of the grandmothers themselves.

To summarize so far: Among the children the boys have the worse situation. And in the young married groups, women present the bigger problem. Apparently it is harder in the suburbs to be a boy or to adjust to the role of married woman, both in part because Dad is so busy "trying to make a buck" he has no time for them. Somewhere there must be a point where ratios of single patients of each sex are equal. In each community: urban, suburban, and rural, this "cross-over point" comes at a different age. In ours it comes at about the age of thirty.

THE UNMARRIED ADULT

The restless, competitive, stressful environment is hard on many marginally adjusted single men. They often feel the strains and

seek medical and psychologic help. Single women in Bergen County are better off at the younger ages. Girls who are in a dilemma regarding marriage and women's role can obtain employment in Bergen County, and thus maintain self-respect and some degree of emotional equilibrium. As they approach thirty, their hopes for eventual marriage wane and job opportunities diminish.[10] They suffer anxiety and tension. In communities with few job opportunities for women, and less strain on men, the "cross-over point" comes earlier. In rural communities where they have few career opportunities but marriage, there are more emotionally upset younger single women than men. Generally women's adjustment is harder in America; but less so for single women in Bergen County.

WAVE OF THE FUTURE

OUR complicated living seems to breed serious emotional disorders. Schizophrenia is still our number one health problem.† Although better methods of medical management of the psychoses have resulted in a higher discharge rate, not much has been done to prevent the development of the disorder. The rate in the United States (and also in the USSR,[7] another complicated, mobile, rapidly upwardly striving materialistic society) seems to be rising. And the emotional disorder rate in fast-growing Bergen County is probably among the highest. Economists tell us that Bergen County will have to assimilate another 350,000 new residents in the next ten or fifteen years. Can we learn from these past experiences not only to prepare economically but also psychologically for this invasion?

What are the difficulties? Will the schools continue overcrowded? This would mean more double sessions and more crowded classes, and more emotional tension for mothers and children. Will recreational facilities continue overtaxed? Will clubs and organizations have no room for new members? Will there continue to be almost a 100 per cent turnover in children's club leadership every few years as the experienced parents quit under the tension and strain? This is hard on newcomers and older residents, too. Must the old people continue to be shuffled off to nursing homes for lack of activities and respectable responsibilities geared to their abilities and needs?

The country and its citizens in their enormous material growth have been so busy getting ahead, that neither individuals nor the country as a whole have done enough to keep the social institutions, the family, the community service organizations in balance with the needs. So the less fortunate have fallen by the wayside. Are they still expendable?

WHAT IS THE ANSWER?

THE emotional problems of the mobile newcomer may not prove to be too difficult to manage psychiatrically. There is little truth in the traditional picture of psychiatry as involving a couch, a bearded doctor, an endless bank account, a Viennese accent and visits extending forever. (One patient wondered why there were no blue lights in her psychiatrist's office!) However, here is one simple fact to remember—and it probably applies to any rapidly growing suburban community: 40 to 50 per cent of Bergen County's children and young married women are new suburban immigrants. Their problems are generally acute and of recent origin, in the category of situational maladjustments. Seventy per cent of these respond satisfactorily to fewer than 20 psychotherapeutic sessions. The average is six. These patients need to understand how to adjust to a new way of life. They learn quickly once they know what to do.

Prevention: Although faster, more economical psychiatric treatment is a step forward it is not nearly as important as prevention. Already the community is coming to grips with this. Bergen County, like many "new" areas, will have more industry. This will mean less of the commuting problem and its consequent strains.

†Not quite. In terms of mental hospital beds occupied, schizophrenia is number 2, not number 1. The top spot goes to the senile psychoses which account for considerably more hospitalization than does schizophrenia. And in outpatient clinic facilities, schizophrenia is also number 2, since the commonest cause for seeking clinic care is psychoneuroses not schizophrenia. However, schizophrenia is our number 1 health problem in terms of manpower destroyed by emotional illness. It strikes people at the dawn of adult life, and thus robs society of much more manpower than does a senile psychosis. And schizophrenia is generally more disabling than psychoneurosis.—Editor.

Men's and women's clubs, churches, the public health and medical groups, hospitals, schools and other organizations are trying to face different aspects of the problem. Soon we will need to put all the individual efforts into a rational combination.

EXPERIENCE has demonstrated the importance of social institutions and organizations in maintaining an individual's emotional equilibrium. Parents with limited time for activities with their children will make the best use of this time by entering with them into such groups as the Boy and Girl Scouts, YMCA's, and similar activities. Schools may do well to encourage and assist all children to be active in one or more clubs and activities. Constructive socially acceptable outlets for youthful energies in association with other stable children and adult counsellors have a considerable therapeutic and preventive psychiatric effect, especially against juvenile delinquency. Clubs may provide male substitutes for the busy, commuting, often-absent-from-home father. And many a man who has not become a success in the business "Big Leagues" can become a "big-shot" in the Little Leagues.

Similarly, geographically mobile families, transferred by industrial organizations or the military, can minimize the possible strains by having family activities and memberships in nationwide groups. If the family has time for regular pleasures together not so much is lost each time they move. A wife and mother who has been active in the PTA or similar organizations readily finds a place in the new community. A husband who is experienced in businessmen's clubs and YMCA activities can readily transfer from one local chapter to another. And the boy in the Scouts or school science club knows how to fit into a similar role in Englewood, Chillicothe or San Diego. With a definite place in society, with friends and useful outlets for energies, they all will be less likely to feel the disruptions of geographic mobility.

There can be hope in the years to come that, as the community develops a more tolerant, loving, helpful and understanding attitude towards all its members, children from broken homes and mobile families will find security in organizations and groups outside the family. The fatherless boy will find understanding and guiding father-substitutes in school and clubs and will not so readily develop an emotional disorder. The new neighbor will be welcomed into the development and immediately be let to know that she can depend on her neighbors in time of need as well as for friendships.

What can the physician do? He can encourage his patients to continue to move forward socially, economically and educationally, but to learn to do so at a slower and more reasonable pace. Patients should listen to the complaints of their bodies. When heads ache, stomachs pain, and muscles are tense, their owners are pushing themselves too hard. When these symptoms develop, the man should not stop his work and suffer a depression. Instead, he should take one less course in night school, make one less sales call a day, buy one less appliance on time. He may live a little longer and more happily. He will get where he wants in the long run, and will have more fun in the process. He should find more time to have a "catch" with his son, incidently getting some much needed exercise and fresh air himself, take his wife to dinner and the family to the museum. They will all get ahead, and with fewer medical bills.

A PLACE has to be found for older people—perhaps low cost apartments, day centers and part-time employment. Many of the women certainly make excellent baby sitters. Men and women at the involutional period can find a new status with their families and importance in the community. Experienced older parents can learn in their clubs and organizations to serve as guides, assistants, and counsellors without dominating younger ones. Part-time jobs, both salaried and volunteer, will help many married women solve the dilemma of their conflicting roles.[10] And assistance from the older, more experienced women will do much to prepare them for their child-rearing and also let them get away from it for a breather.

Single people need to enter more into serv-

ice organizations to bring them into contact with each other and the rest of the community in constructive play work and the arts. Fairleigh Dickinson's program and the adult education programs of the schools are making great contributions to the mental health of single people. If you practice in the New York City area, you may have patients who would be disappointed at the news that Columbia University is even considering a retrenchment in their School of General Studies. For what is needed is an expanded opportunity for the adult to take part-time college courses.[8] High school organizations would do well to bring some of the adolescent girls into greater contact with children of pre-school age. The children will benefit, the girl will learn about child rearing, and the mothers, hospitals, nursery schools and children's homes will receive much needed assistance.

Perhaps this is the time for a re-examination of American cultural values. Already some economists[1] are questioning the necessity of continued emphasis upon ever-increasing production in our society of abundance. Rapid economic growth encourages an individualistic, materialistic, "getting ahead" attitude by the citizenry. But you cannot buy love, respect, and a good life. Over-emphasis on "getting ahead" conflicts with interest in home and family life. Men get ulcers, wives feel in a rut, marriages and children suffer. A reorganization of values, with a questioning of the hectic urgency of material growth, and a little more consideration of community and family activities, of education, and of constructive leisure seems to be indicated.

SUMMARY

THE evidence seems to indicate that higher incidence rates of emotional disorder are related to the strains of mobility: economic, social and geographic. And this does not seem to be just a problem of Bergen County, but of the entire nation. Bergen County has a little more of the mobility problem. By comparing Bergen's incidence of emotional disorders to that of other communities, the differences can be measured, rates determined, and evidence provided to support the hypothesis. Efforts on the part of the community leaders (physicians in the vanguard) to ease these strains by cautioning their patients not to knock themselves out trying to get ahead materially, by suggesting a little re-evaluation of our individual and national goals, and by assisting in the development of a more integrated community, may have considerable prophylactic effect.

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Complications of Mesenteric Cysts*

Report of Two Cases

In all the world's literature, only 600 cases of mesenteric cyst have been reported. To this scanty collection, Dr. Mattioli adds two new cases, both with successful outcome.

It is difficult to make an accurate preoperative diagnosis in cases of mesenteric cysts, notably the rarest of abdominal tumors.[1,2] The difficulty is increased by the presence of complications. It is in support of this statement that the two cases reported in this article are considered worthy of presentation. The subject is usually given scant or cursory discussion in textbooks.

In 1507 Benevieni,[3] a Florentine anatomist, made the first observation of a mesenteric cyst on performing an autopsy and classified this as "an anatomical marvel."[4] The first recorded description of a chylous cyst was made in 1842 by Rokitansky[5] from autopsy. Tillaux, in 1880, performed the first successful operation on a cystic tumor of the mesentery.[6] In 1883 Pean successfully marsupialized such a tumor.[5] By 1940, Loeb[7] had estimated that there were not more than 600 cases reported in all the world's literature. The consistent rarity of this tumor has been illustrated by Oleson,[14] Judd and Crisp,[15] Roller,[16] and Costello.[17] In 1947, Judd and Beahrs[8] reported only seven chylous cysts in one million patients at the Mayo Clinic. Gross[18] suggests that these cysts originate from misplaced bits of lymphatic tissue. It is further suggested that fluid accumulates because there is no communication with the remainder of the lymphatic system. Guthrie and Wakefield[9] suggest that these cysts arise from true diverticula of the small intestines which cross into the mesentery and become pinched off. These may be absorbed; but they also may persist to form cysts. They feel that this theory will be substantiated when someone finds a carcinoma developing in one of these cysts. And, indeed, a case of embryonal carcinoma of a mesentery cyst was reported by Peterson[10] in 1940.

Peterson[10] divides mesenteric cysts into three groups: (1) *Embryonic group*: cysts arising from embryonic remnants and sequestrated tissue, among which are serous, chylous, sanguinous and dermoids; (2) cysts which develop from sequestration from the bowel, including Meckel's diverticulum; and cysts of urogenital origin; (3) *Pseudo-cysts*: Cysts of infective origin; hydatids and cystic degeneration of tuberculous nodes; and cystic malignant disease.

The most common clinical symptom is a slow-growing, painless, freely-movable abdominal tumor.[6,19–23] Acute intestinal obstruction associated with "crampy" abdominal pain may call the surgeon's attention to the abdominal mass.[10,20,24,25] In the collective reviews of 71 case histories Burnett, Rosemond and Bucher[26] state that pain was the presenting symptom in 82 per cent of the cases. They say that in the 71 case histories an abdominal

*This is a thesis submitted to the Faculty of the Graduate School of Medicine of the University of Pennsylvania, in partial fulfillment of the requirements for the degree of Master of Medical Science (M.Sc. (Med)) for graduate work in surgery. The cases are from the Newcomb Hospital, Vineland, N. J.

mass was felt in 58 per cent. Gross [18] has emphasized the frequent occurrence of an abdominal mass upon examination.

Mesenteric cysts have been found in both adults and infants, with the highest incidence in the fourth decade, and the lowest in the first and sixth decade.[6] These cysts seem to be twice as common in women [6] as in men. They occur primarily in the white race.[6] One case has been reported in a Chinese boy.[27]

Swartley [3] has classified the complications of mesenteric cysts as follows: obstruction, peritonitis as a sequel to obstruction, hemorrhage into the cyst, rupture of the cyst, torsion of the cyst and pressure upon other organs. Cases have been reported [28] where the presenting symptom was associated with an acute surgical complication as intestinal obstruction following volvulus, angulation of the bowel, adhesions or intussusception.[29] Intestinal obstruction due to volvulus as a complication to mesenteric cyst in a congenitally malrotated small bowel is one of the rarest complications.[30] In 50 per cent of the recorded cases chronic or acute intestinal obstruction was the most frequent complication.[9] Symptoms of partial or complete intestinal obstruction are due to large cysts, incompletely filled and of a soft consistency, resulting in compression or strangulation of the adjacent intestine.[31]

In a series of cases reported from the Mayo Clinic [9] "cysts less than 25 millimeters in diameter failed to produce any physical signs or symptoms." Yet the same authors noted that in these small mesenteric cysts a sudden hemorrhage or twisting of the pedicle may cause an acute abdominal crisis.

Upon rupture of a mesenteric cyst two types of fluid have been found. These may be either clear straw colored, or milky chylous in appearance.[24,32-35] Chylous ascites has been reported frequently, but chyle peritonitis secondary to a ruptured chylous cyst is extremely rare[36] and deserves consideration when nonodorous milky fluid is found in the abdominal cavity.

Mesenteric cysts may be multilocular or unilocular; or they may be multiple or single. They vary from a pea-sized bleb to an enormous growth filling the abdominal cavity.[8] Commonly, these cysts are not completely filled and are flabby. They may present themselves in dumbbell shape, resulting from the cyst's projecting out from either side of the mesentery and straddling a loop of bowel like a saddle.[30] Among the largest mesenteric cysts reported is one which contained 1,500 cubic centimeters of fluid.[30] In Gross' series (1953) he reports a case containing 1,200 cubic centimeters of fluid.

Most frequently, mesenteric cysts are found between the peritoneal leaves of the mesentery of the jejunum or ileum.[24,25,37] Rarely are they found in the mesocolon.[23]

The contents of mesenteric cysts may be serous or chylous. The chemical composition of the contents of serous cysts is similar to blood plasma.[18] The chylous fluid found in the mesenteric cysts which originate from the mesentery of the jejunum or ileum contains a great quantity of fat. Chylous fluid is about 1 per cent fat.[38]

Mesenteric cysts should be differentiated from cysts of enteric origin (duplications of the gastro-intestinal tract). In enteric cysts, a thick-walled structure with a serous coat, two layers of smooth muscle and a mucous membrane lining are present. The mesenteric cyst is notably thin-walled and has no muscular coat or mucosal lining. The wall of a mesenteric cyst is composed of connective tissue. In some cases, a layer of flattened endothelial cells may be found on the inner surface. The musculature of the enteric cyst and of the adjacent intestine have the same blood supply. To remove an enteric cyst, the adjacent bowel must be resected. Mesenteric cysts may be shelled out or removed without injury to the blood supply of the adjacent bowel since there is a line of cleavage.[31] Omental cysts are presumed to originate in the same manner as mesenteric cysts and present a comparable histologic picture.[18]

Roentgenologic findings obtained through films of the abdomen, gastro-intestinal series or barium enemas may be the most significant

diagnostic aid.[38] Mesenteric cysts may appear as shadows of wider density displacing the intestine or stomach.[39] Gross [18] states that a gasless shadow may be found displacing the intestine into other parts of the abdomen. Such a shadow may be a valuable diagnostic lead. Very infrequently, the mesenteric cyst may be outlined on the x-ray film as a result of calcium deposits in the cyst wall.[41]

Mesenteric cyst is a surgical condition. The lowest mortality rate, 9 per cent, is achieved by simple enucleation. There is an increase to 25 or 30 per cent in mortality when intestinal resection is done. With marsupialization, the mortality is 16 per cent.[16] However, this last figure may increase if complications of persistent sinus, non-obliteration and intestinal obstruction occur.[8] Primarily, two methods of surgical treatment are recommended today: *enucleation*, which is the preferred procedure, and *excision* of the cyst with intestinal resection if the cyst is severely adherent to the intestine. Marsupialization is not recommended.[18]

CASE ONE

A 17-year old boy was admitted to Newcomb Hospital on January 5, 1955, complaining of severe abdominal pain of three days' duration. He had no nausea or vomiting. He complained of a "heavy" feeling throughout the abdomen for two days prior to onset of pain. Two hours after he had eaten supper on January 4, 1955, the abdominal pain became localized in the left flank. He took Epsom salts that day and the next morning had a normal bowel movement. The pain remained localized. He felt relief when lying on his stomach or left side. His past medical history was noncontributory. On admission, he had generalized abdominal tenderness. Peristalsis was normal. Rectal examination was negative. Bilateral enlarged lymph nodes were noted. There was tenderness in the left costavertebral region and tenderness on deep palpation of the left kidney. Our presumptive diagnosis was pyelonephritis, possible perinephritic abscess and possible Meckel's diverticulitis. Blood count was negative. Except for "occasional" white blood cells, urine analysis was within normal limits.

Flat plate of the abdomen showed minimal dilatation of portions of the jejunum which could be indicative of an early local ileus.

On January 6, intravenous urogram revealed considerable small bowel distention with no signs of perinephritic abscess. The possibility of pyelonephritis still could not be excluded. Cystoscopy was essentially negative. Urine culture was sterile after 48 hours. The patient continued to have pain in the left flank. He became nauseated and vomited twice. The acute pain in the left lower abdomen had progressively worsened. The rebound and the rigidity had increased. Peristalsis was present and active. He received parenteral fluids. Temperature, pulse and respirations continued to be normal. A second blood count was substantially normal. In the urine, the number of leukocytes was found increased on the second urine analysis.

On January 7, he continued to show signs of increased peritoneal irritation, although there was no distention. He did show point tenderness in the left abdomen. He continued to be nauseated and vomited a third time. His temperature now was 101, as was his pulse. Electrolyte studies were essentially negative. Barium enema revealed evidence of a dilated ileum causing a partial bowel obstruction which could be due to a kinking of the distal ileum or to an inflammatory reaction secondary to peritonitis.



Figure 1. Twisting of the distal ileum with area of smooth narrowing (arrow), and ileum proximal showing dilatation.

No other abnormalities were noted upon inspection of the abdomen.

A Levin tube was inserted. A pre-operative diagnosis of complicated Meckel's diverticulitis was made.

Operation: After the spinal anesthetic had been given and the left rectus muscle had become relaxed, a mass about the size of an orange was palpable in the left mid-portion of the abdomen. A lower left paramedian incision was made, and upon opening the peritoneum a large quantity of clear serosanguinous fluid was seen. There was dilatation of the ileum distal to the tumor mass. The iluem was partly kinked and partly rotated around the greater omentum, which was attached to the tumor mass adjacent to the jejunum. This was a large, tense fluctuant mass measuring 5 centi-

meters in diameter and 2 centimeters from the wall of the jejunum. The mass was found in the leaves of the mesentery. On its anterior surface, it had perforated, and the greater omentum was attached at the point of perforation. The tumor mass was congested and had a reddish-gray appearance.

The omental attachment was resected 5 inches from the mass. We saw innumerable large lymph nodes throughout the mesentery of the small bowel, the largest measuring 15 millimeters in diameter. The jejunum containing this large mass was brought into the operative field. Since the blood vessels were directly incorporated with the mass, the adjacent bowel and the tumor were resected together. Several centimeters of jejunum and a wedge of the mesentery were removed together with the tumor mass and a portion of omentum. A primary end-to-end anastomosis was done.

Pathologist's report: The specimen consisted of a 42-centimeter segment of small bowel and attached portion of mesentery. The latter contained a soft, fluctuant mass measuring 5 centimeters, and its anterior surface was covered by a piece of omentum. The mass was 2 centimeters adjacent to the intestinal wall. It was grayish-yellow in color and had a smooth, glistening serosal surface. There were numerous mesenteric lymph nodes. Upon opening the intestinal tract the mucosa was found to be intact. There was no evidence of communication between the cyst and the intestinal tract. Section of the cyst revealed the presence of a putty-like, thick, yellow material. The cyst wall averaged 3 millimeters in thickness. The cyst wall consisted of granulation tissue composed of young capillaries and fibroblasts with scattered neutrophiles and lymphocytes. Vacuolated macrophages were also present. A definite epithelial or mesothelial lining could not be found.



Figure 2. The gross appearance of a perforated chylous mesenteric cyst with a portion of omentum sealing off perforation.

The patient had an uneventful course post operatively and was discharged from the hospital on January 17.

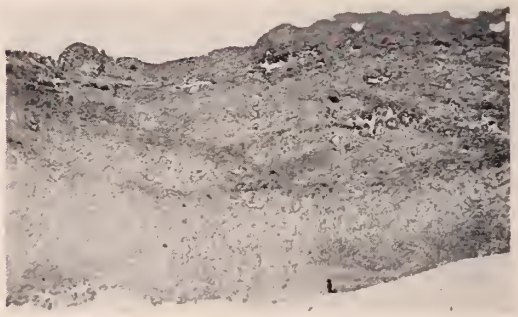


Figure 3. Photomicrograph of mesenteric cyst wall (low power) showing the absence of mesothelial or epithelial lining, and the wall composed of granulation tissue reaction with occasional dilatation of lymphatics.

CASE TWO

A 6-year old girl was admitted to Newcomb Hospital on December 3, 1955, complaining of acute pain in the right lower abdomen associated with nausea and vomiting of 12 hours' duration. Past medical history was non-contributory. She had a temperature of 101. Her pulse was 100. Pertinent physical findings were confined to the abdomen and disclosed right rectus rigidity, generalized rebound tenderness, diminished peristalsis and a large palpable mass over McBurney's point, about 3½ inches in diameter. Rectal examination revealed tenderness referred to the abdomen. X-ray of the chest was negative. The white cell count was 27,950. Urinalysis, December 3, 1955, showed albumin: plus 1. The pre-operative diagnosis was: appendicitis with secondary abscess and peritonitis.

Operation: A McBurney incision was made and when the peritoneum was opened there was noted a copious amount of serosanguinous fluid. The appendix was edematous and markedly injected, but was not associated with the intra-abdominal tumor mass. Digital examination revealed a large mass in the right lower quadrant and upper portion of the pelvis adherent to the anterior peritoneum. A Weir extension of the McBurney incision was done. The saddle-shaped mass was mobilized and found to be adjacent to the jejunum and in its mesentery. When this mesenteric cyst was brought into the operative field it was found to be perforated, and a large quantity of clear serous fluid escaped. However, it was noted that there were other compartments of the cyst which still contained fluid.

A marked amount of fibrinous exudate was present on the anterior surface of the cyst. Resection of the jejunum and a wedge of the mesentery containing the mesenteric cyst was performed, followed by an end-to-end anastomosis. Appendectomy was also done. The abdomen was closed in



Figure 4. Multilocular saddle-shaped mesenteric cyst at operation.

layers, and a large cigarette drain was inserted in the right lateral gutter down into the pelvis.

Pathologist's report: The specimen consisted of 16½ centimeters of small bowel, uniform in diameter. At a point 3.5 centimeters from one of the resected edges there was a cystic structure of soft consistency and arising in close proximity to the lateral edge of the bowel, continuing in a U-shaped fashion around the attached mesenteric portion. The cyst wall was injected, hemorrhagic, dull and partially covered by a gray-white exudate. Upon opening the bowel, two small superficial non-connective ulcerations were found. The structure was 7 centimeters long, 3½ centimeters thick and 3½ centimeters wide. Sections showed that it was multilocular. It contained several thin septa. These compartments were filled with pink gelatinous material. The cyst wall in some areas measured less than 2 millimeters in thickness. Microscopic examination revealed portions of the intact jejunum. Its wall was edematous and infiltrated by mononuclear cells. The cyst and its septa consisted of fibro-connective and adipose tissue infiltrated by numerous segmented neurophiles and mononuclear cells. Scattered macrophages containing vacuoles were seen. There was no epithelial lining present. Pink acidophilic staining material was seen in some of the spaces. Areas of granulation tissue reaction were also present.

The child enjoyed an uneventful postoperative course and was discharged on December 13, 1955.



Figure 5. Lower portion of picture shows mesenteric cyst with site of perforation and marked degree of fibrinous exudate.

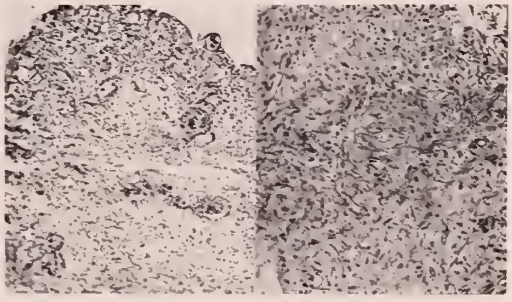


Figure 6. Photomicrograph of mesenteric cyst wall (high power) showing granulation tissue reaction and numerous fibroblasts with no endothelial lining.

SUMMARY

1. Two cases of *true* mesenteric cysts have been presented. One occurred in the first decade of life and the other in the second decade. Both patients were operated on as emergencies. One had a pre-operative diagnosis of acute Meckel's diverticulitis and the other had a pre-operative diagnosis of perforated appendicitis with abscess formation and peritonitis.

2. In each instance pain was a prominent feature of the illness. In one case, the pain was associated with partial intestinal obstruction due to kinking of the ileum. This had resulted from perforation of the mesenteric cyst and a sealing off of the perforation by the omentum. In the other case there was high fever, leukocytosis and evidence of acute inflammation of the cyst wall which had also perforated and sealed off.

3. In both cases, a mass was detected preoperatively, although in the older patient this mass was not detected until the anesthetic had

Bleeding from the *fallopian tube* is most commonly associated with ectopic pregnancy. This bleeding, however, is more likely to be mostly concealed rather than evident. Bleeding may also occur with inflammatory conditions, as well as the rather rarely occurring primary tumors of the fallopian tube.

Bleeding from the *ovary,* which of course is generally concealed, may be due to a ruptured vessel at the time of ovulation, or to ovarian pregnancy. It may also occur as the result of rupture of an ovarian cyst.

When analysing the individual situation relative to the causes of irregular bleeding two important factors should be kept in mind: (1) Rule out malignancy; and (2) Blood dyscrasia may be the cause regardless of the evident pelvic pathology.

For a more practical survey of abnormal bleeding, the subject may be considered under arbitrary age groupings. These groupings are:

1. Before puberty
2. At puberty
3. During the reproductive life
4. At the menopause
5. After the menopause

BEFORE PUBERTY

BEFORE the usual age of puberty, genital bleeding in the female is not a common symptom. When it occurs it is usually due to some type of trauma, and occasionally to infection. At this age one must also keep in mind the rare feminizing ovarian tumor, such as thecoma or granulosa cell tumor. In the latter cases, the child will show signs of precocious sexual development, such as pubic hair and enlarged breasts. Management of the bleeding is dependent upon history, examination, and elimination or correction of the cause.

AT PUBERTY

AT PUBERTY the most frequent cause of abnormal bleeding is dysfunction. But the doctor must not allow this to interfere with a diligent search for other causes, such as blood dyscrasia, pregnancy complications, or neoplasms. Dysfunctional uterine bleeding is most common at the beginning and end of menstrual life, but may occur at any time between the menarche and the menopause. The exact hormonal disturbance responsible is not completely understood, but absence of ovulation is a constant finding.

The blood loss may be such that no alarm need be entertained, and little if any therapy, except reassurance, applied to the young teenager and her mother. On the other hand the loss of blood in an occasional case may be exsanguinating, and even fatal, and tax to the limit the skill of the attending physician.

This bleeding differs from normal menstruation in three ways. It is not regularly cyclic in character. It is not self-limited, but may be prolonged for several weeks, and may be exsanguinating. It is not associated with the usual molimina; that is, cramps, etc.

Diagnosis cannot be made without careful history and physical examination, including a pelvic examination. The latter need not always be vaginal. Rectal digital examination may be sufficient. Laboratory tests include urinalysis, blood count, coagulation and bleeding time, and blood platelets, as well as differential count. Test for thyroid function should also be done. Chest x-ray may be helpful. The doctor should as far as possible, rule out organic disease. The diagnosis is not made simply by exclusion, for a characteristic of this type of bleeding is the absence of ovulation. Curettage at the proper time is essential in the study. It may be temporarily delayed in young girls until a therapeutic test is given. Curettage may also have some therapeutic value.

Treatment is aimed at control of present bleeding and establishment of the normal menstrual cycle.

The control of bleeding may be accomplished by the use of large doses of estrogenic hormone; by the use of progesterone; and by the use of testosterone. We prefer either estrogenic hormone or progesterone. The acute episode can usually be controlled with stilbestrol, 5 milligrams one to three times a day for five days. We start with stilbestrol because it is less expensive. Progesterone will produce a similar effect, as will

testosterone. I feel somewhat safer, however, in not using testosterone in this younger age group. If medical therapy does not properly control the bleeding, a curettage should be resorted to for both therapeutic and diagnostic reasons.

When the acute episode of bleeding is controlled the next step in treatment is to establish the normal cycle. This is done by giving small doses of estrogenic hormone (stilbestrol, 0.5 milligrams daily or some other more expensive hormone if you prefer) for three weeks. During the third week progesterone (Pranone® 10 milligrams three times a day by mouth) daily is given. During the fourth week, no medication is given. This cycle is repeated each month for three to six months, and thereafter as necessary to maintain the normal cycle. Some of these cases are stubborn and need to be followed and treated from time to time over a period of several years.

DURING REPRODUCTIVE LIFE

DURING the reproductive life of woman, the most common cause of abnormal bleeding is some aberration of pregnancy. Bleeding during the first trimester is usually due to miscarriage (threatened, incomplete, or complete) or ectopic pregnancy. If history and abdomino-pelvic examination and blood studies do not make the diagnosis clear, the relatively simple procedure of colpocentesis may prove invaluable. In a small proportion of cases the diagnosis may not be clear without a colpotomy or exploratory laparotomy. When the diagnosis is established no time should be lost in carrying out the necessary surgical procedure.

Bleeding later in pregnancy is usually managed by the obstetrician.

During the reproductive period of life, the attending physician must be ever alert to the presence of neoplasia, benign or malignant. Bleeding, even severe, may be due to a benign condition; and scant bleeding, or only spotting after coitus or exertion, may be associated with invasive cancer. Bimanual and speculum examination, augmented by cytology and biopsy properly performed and interpreted, almost invariably bring the diagnosis into the open, and appropriate therapy can be applied.

This period of life is also not immune to bleeding caused by trauma, dysfunction, infection, systemic disease, or psychologic factors.

AT THE MENOPAUSE

UNFORTUNATELY, at the menopause abnormal bleeding is too commonly considered to be dysfunctional, or "due to the change," and the woman given hormones of various sorts and amounts without adequate diagnostic studies. This is inexcusable. Indiscriminate hormone therapy in any woman is a sign of poor medical education. One cannot over-emphasize the importance of careful, regular pelvic examinations in women, especially as they approach this age. Cancer of the cervix could be almost eliminated as a cause of death if such examinations were conscientiously carried out in all women from the age of 30 years until after the menopause. Not only would such examinations produce phenomenal results in relation to death rates from carcinoma of the cervix, but other pathology, both benign and malignant, could be picked up at an early date in most instances.

Malignancy of the cervix and corpus are *not* the most common causes of bleeding at the menopause, but they should be thought about and eliminated first. Other causes are dysfunction and benign lesions of the pelvis; such as polyps, fibroids and cysts. These are usually discovered in the course of careful studies. The presence of a myoma does not eliminate carcinoma as a cause of the bleeding. And not until all these organic causes of bleeding are eliminated should the patient be treated for dysfunctional bleeding.

It is surprising how often an endometrial polyp can be missed even with careful curettage. If one explores the endometrial cavity with ring forceps, it is surprising how frequently such a procedure is rewarding.

Women who continue to menstruate past the age of 50 show a higher incidence of uter-

ine cancer, and thus demand more careful observation.

POSTMENOPAUSAL BLEEDING

THIS may be variously defined in different clinics. Some set a standard of any bleeding that occurs two years after the cessation of normal menstruation; others have established a period of one year amenorrhea, and others a more strict period of six months. One year is more generally used as the period of amenorrhea.

In 1955 at the Cooper Hospital we reviewed 100 cases, using six months as the period of amenorrhea. Results were as follows: 42 proved to be malignant; 55 were due to benign lesions, and in 3 cases the cause was undetermined. Of the malignant cases, 29 were of the corpus, 11 of the cervix and 2 of the ovary. Of the benign cases, 12 were endometrial polyps, 3 cervical polyps, 22 endometrial hyperplasia, 7 atrophic endometrium, 5 uterine myomata, 3 chronic cervicitis with ulceration, 2 uterine fibrosis and 1 cystadenoma of the ovary. The 3 cases listed as undetermined were reported by the pathologist as secretory endometrium.

This study is summarized in the following table.

POSTMENOPAUSAL BLEEDING

42 *malignant*:

29	corpus	26 adenocarcinoma
		1 adenoacanth.
		2 sarcoma
11	cervix	7 epid. & 4 adeno. papillary cystadenoca.
2	ovary	

55 *Benign*:

15	polyps	12 endometrial
		3 cervical
22	endometrial hyperplasia	
7	atrophic endometrium	
5	myomata	
3	chr. cervicitis with ulceration	
2	uterine fibrosis	
1	cystadenoma of ovary	

3 *Undetermined*:

Reported as secretory endometrium

The incidence of malignancy is higher in this group than reported in most other studies. I cannot account for this except that we work under very crowded hospital conditions, and it is difficult to get patients into the hospital; so perhaps in the period of waiting for a hospital bed, many of those cases which were not serious were eliminated by office procedures.

Bleeding due to exogenous estrogens, administered so freely these days, is sometimes encountered. This causes concern in the postmenopausal woman, and one must make certain the diagnosis by careful examination, including endometrial studies. Elimination of estrogen therapy, or combining same with balanced dosage of testosterone is the method of management.

Psychologic factors as a cause of abnormal uterine bleeding must certainly be considered, but in making this diagnosis one must take care to eliminate any and all organic causes. There are certainly emotional stress situations that may be precipitating factors.

SUMMARY

A CLINICAL review of bleeding factors in gynecologic patients has been presented. This had been discussed under arbitrary age groupings. The value of routine, thorough periodic examinations of the female pelvis is emphasized. Note has been made that the amount of bleeding bears little relationship to the serious nature of the underlying pathology. Some points in differential diagnosis have been given. And an analysis of 100 cases of postmenopausal bleeding has been reviewed. When dealing with a case of abnormal bleeding two very important etiologic factors should always be borne in mind; *i.e.*, first rule out malignancy, and second that blood dyscrasia may be the cause of bleeding regardless of the pelvic findings.

719 Cooper Street

Bonanno, P. J., Teaneck: My congratulations to Dr. Shipps for presenting a broad and clinically important problem in a concise and practical manner. His practical approach to the problem is evidence of years of experience in this field.

Clinically significant bleeding during puberty and adolescence is relatively infrequent, considering the delicate hormonal mechanism which is initiated at this phase of a woman's life. Actually, these cases make up a very small proportion of a gynecologist's daily practice.

It has been my experience that these young girls respond very well to progesterone in adequate dosage, and I stress *adequate* dosage. Since these young girls usually have anovulatory cycles with associated relative hyperestrinism, sufficient progesterone must be given to correct this relative hyperestrinism. My practice has been to give progesterone 100 milligrams intramuscularly and then in the following cycle to give progesterone or progestational hormones such as Norlutin® cyclicly until two normal cycles are established. Five to 10 milligrams of Norlutin* daily for 10 days starting on the 15th day of the cycle or Delalutin† 2 cubic centimeters on the 15th day of cycle for 2 cycles. The only exception to this routine is the girl who presents herself with alarming bleeding and hemoglobin below 10 Grams. To this patient we give intravenous Premarin‡ 20 milligrams every 4 hours until bleeding stops then Premarin‡ 1.25 milligrams or stilbestrol 0.5 milligrams daily for 20 days. On the 18th day after starting estrogen, we give intramuscular progesterone 100 milligrams. The following cycle we use Norlutin* or Delalutin† as previously outlined. I have not as yet had to do a curettage on any girl under 16 years of age, but this, of course, could as Dr. Shipps pointed out, be a necessary procedure.

Dr. Shipps has covered bleeding in the reproductive and menopausal age group adequately. I have nothing to add except to re-emphasize the value of culdotomy with or without the use of special culdoscopes as a diagnostic procedure. I make a one-inch incision in the posterior fornix and using narrow Deaver retractors or a Doyle culdoscope explore the pelvis. Long Babcocks are used to bring the tubes and ovaries into view.

In the post-menopausal age group, in my own personal series, the proportion of malignancy is much less than in Dr. Shipps' series, being only 32 per cent. Of these, 27 per cent were in the fundus. For all diagnostic curettage, I use the Randall kidney stone forceps with ¼ curve to explore the uterine cavity after the cervix is dilated and before starting the curettage. The advantage of the Randall kidney stone forceps is that it is finer and smaller than the ring forcep or even the average polyp forcep. It can be introduced more easily, especially through an atrophic cervix, and being smaller, the cavity of the uterus can be more readily explored with it. I explore the uterus with the Randall forceps first, before doing the curettage, because the curette could break up a polyp and make the diagnosis difficult for the pathologist.

A good point to remember when using the Randall forceps is that while exploring the uterus, if the clamp picks up a large polyp or a small pedunculated submucous fibroid, the jaws of the clamp will twist and overlap. When this happens, you know you have something large inside the uterus. At that point I dilate the cervix further and introduce either a ring forcep or a regular polyps forcep.

Radium or x-ray as a treatment for non-malignant bleeding is mentioned only to be condemned, except where surgery is absolutely contraindicated. The incidence of malignancy developing in patients who have received radium or x-ray for bleeding episodes during the menopause is four times as great as that in the overall picture.

*Norlutin® is the Parke-Davis tradename for norethindrone.

†Delalutin® is the Squibb tradename for hydroxyprogesterone.

‡Premarin® is the Ayerst tradename for conjugated equine estrogens.

Passive Protection

Inoculation of pregnant women with Salk vaccine confers antibody protection in their infants for three months after birth, studies of 142 women show. Drs. Gordon C. Brown and Catherine J. Carroll (University of Michigan) report that the higher the protection given the prospective mothers, the longer the passive protection for the infants.—*GP*, June, 1958.

Incidence of Blindness

Approximately 28,500 Americans became blind in 1957. This increased the total blind in the United States to 339,000.

The rate of blindness is increasing. This is attributed in part to the fact that Americans are living longer and that the blinding eye diseases are most prevalent among our senior citizens.

A. Russell Sherman, M.D.

Newark

Appraisal of Loss of Visual Efficiency After Eye Injury*

In many fields of medicine, disability must be expressed narratively, not numerically. In ophthalmology, however, an impairment of visual efficiency can be expressed in numbers. The problem is how to express it so it will be clear to an ophthalmologically unsophisticated referee, attorney or adjuster. Dr. Sherman suggests a way.

Appraisal of loss of visual efficiency after eye injury is usually made for the information of a lay person or agency. The explanation should, therefore, be expressed in lay terms. If the loss is less than total, a system of coverting Snellen fractions, diplopia, field loss or other visual disturbances into percentages must be available.

In New Jersey there has been established by statute, a schedule of payments based on loss of certain specified members, loss of vision or loss of hearing. No method for determining the payments resulting from partial loss of vision is prescribed. In theory, the examiner may use any method he chooses. In practice, in order to achieve reasonably uniform appraisals by different examiners, and to avoid total confusion, a schedule has been recommended by The Medical Society of New Jersey for the expressing of appraisals in percentage terms. This has been adopted by the Department of Labor and thus been given the effect of law in disputes involving eye injuries arising out of and in the course of an injured person's employment.

At present, the schedule in use is that of 1923. A committee of the New Jersey Academy of Ophthalmology and Otolaryngology has drawn up a revised recommended procedure which, it is hoped will be adopted by The Medical Society of New Jersey. This procedure, like the earlier one, assumes that compensation awards are to be based on impairment of one or more factors of visual efficiency. This is in accord with the wording of the statute *viz*: "16. For the loss of vision of an eye, 200 weeks," and "22 . . . where the usefulness of a member or any physical function is permanently impaired . . . " No mention is made of scars or other deformities and one is not warranted in using them as a basis for determining disability, unless they cause impairment of function.

Making an appraisal which satisfies the ophthalmologist is usually only half the task. There remains the reporting of his findings to the lay person or agency, so that they may be implemented, so to speak. The kind of report prepared for a scientific journal or written for another physician (particularly another ophthalmologist) would be so much jargon to the average lawyer or insurance representative. The writer of such a report may believe that, by confusing the reader, he demonstrates his superior knowledge. The impression created in such cases, however, is more likely to be that of ignorance or thoughtlessness.

Even such commonly used expressions as

*Read on May 21, 1958 before the Ophthalmology Section of The Medical Society of New Jersey at the Atlantic City Annual Meeting.

"corrected vision" and "correction" will not be recognized by the non-ophthalmological reader as referring to eye glasses. In New Jersey, as a matter of fact, if workmen's compensation is involved, it is fruitless to discuss the subject of corrected vision when appraising loss of visual efficiency. The examiner is not permitted to base his estimate on the corrected visual acuity, when improvement results from optical correction of a defect caused by the injury in question. He is not relieved, however, from examining the refractive condition of both eyes since he must usually have this information to determine whether any of the visual loss results from conditions present before the injury and unassociated with it.

In submitting reports, the situation will be greatly clarified if all mention of glasses or corrected vision is omitted. The examiner need only state what is the loss of visual efficiency from all causes, then specify how much of this loss is due to conditions resulting from the injury in question. One might consider, as an example, a man with a corneal scar of the left eye. Assume the uncorrected vision of each eye to be 20/100, and the vision with O. U. +2.00 to be right eye 20/20, left eye 20/50. One should take as the loss of visual efficiency, the percentage corresponding to a visual acuity of 20/50, since, in the absence of evidence to the contrary, the refractive condition of both eyes before the injury was presumably similar. If one finds that the vision of the left eye can be improved with +1.50 +1.50 ax. 60 to 20/20, and there is sufficient scarring to produce the astigmatism, 20/50 should still be taken as the basis for computing the loss. In such a case, one can simply state that there is some visual impairment of each eye resulting from hyperopia, a pre-existing condition, and that there is additional impairment of such and such percentage resulting from the corneal scar of the left eye, or from the corneal scar and the astigmatism associated with it. If, on the other hand, the best correction for each eye is +1.75 +1.75 ax. 90, resulting in a visual acuity of 20/20, O. U., the obvious conclusion is that the astigmatism of the injured eye antedated the corneal scar and did not result from the injury.

One cannot always, at the time of the examination, estimate what the permanent visual loss will be. Obviously the impairment from a corneal wound or paretic muscle may diminish in six to twelve months, just as that from a lens injury may increase. In New Jersey, this has been recognized by the legislature which recently provided for a six months' waiting period before the estimate of permanent disability in workmen's compensation cases.

Loss of visual efficiency results from disturbance of visual acuity, of ocular motility or of field of vision—functions which ophthalmologists test repeatedly. If there are objective findings to corroborate the subjective ones, or if two subjective tests (*e.g.* tangent screen and perimeter) corroborate one another, there will not be great divergence between the appraisals of different examiners. Such corroboration in some form is often needed to back up a formal opinion in medicolegal proceedings, and if, as has sometimes been said, it is our business as ophthalmologists to estimate evidence of blindness, it is equally our business, as citizens, to further the cause of justice when we have the opportunity to do so.

605 Broad Street

Arthur Heyman, M.D.
Edward Levitzky, M.D.
Newark

Steroids in the Treatment of Childhood Tuberculosis*

For some time it was taught that corticosteroids were contraindicated in tuberculosis. Dr. Heyman and Dr. Levitzky show here, however, that in combination with antimicrobial drugs, they can be lifesavers.

A startling reversal of medical opinion has been a recent change in thinking about corticosteroids in the treatment of tuberculosis. The concept that steroids were contraindicated was discarded when it was found that, in combination with effective chemotherapy, they proved to be lifesavers in severer forms of tuberculosis. They also prevented chronic disabling sequelae in other types of this disease.

Corticoids are capable of reducing the inflammatory response of those who are hypersensitive to tuberculous infection.[1] Tissue destruction is delayed and there is decreased localization of infection and increased multiplication of tubercle bacilli. Many investigators have shown that the steroids cause rapid extensive clearing of exudative elements, decreased fibrosis, and greater exposure of the bacilli to the antimicrobial drugs.[2,3,4,5,6]

The demonstrated favorable effects of corticoids on the course of childhood tuberculosis led us to treat the following types with combinations of chemotherapy and prednisone (Meticorten®):

1. All patients with a grave prognosis.
2. Those forms known to be relatively uninfluenced by chemotherapy alone.
3. The types which often produce chronic disability.

In the past 18 months, on the Children's Tuberculosis Service of the Essex County Hospital at Belleville, we have selected 13 children in the above categories for treatment with prednisone. Included were 6 cases of miliary tuberculosis, 3 of meningitis, 3 of progressive primary infections, and one pleural effusion. In addition, 2 cases of tuberculous endobronchitis were observed at the Children's Chest Clinic conference at Bellevue Hospital, New

*Read May 15, 1958 at the Annual Meeting of The Medical Society of New Jersey.

1. DiRaimondo, V. C. and Forsham, P. H.: Corticoids and Adrenocorticotropin. *Metabolism*, 7:5 (Jan. 1958).

2. Spink, W. W.: ACTH and Adrenocorticosteroids in Infectious Diseases. New England Journal of Medicine, 257:1031 (Nov. 1957).

3. Bull, P. R.: Chemotherapy of Tuberculosis. Medical Journal of Australia, 1:721 (May, 1957).

4. Cocchi, Cesare: Cortisone and Corticotropin in Tuberculosis. American Review of Tuberculosis and Pulmonary Diseases, 74 (Part 2):209 (Aug. 1956).

5. Raleigh, J. W.: Recent Developments in Tuberculosis. Journal of the American Medical Association. 166:921 (Feb. 1958).

6. Miller, A. B.: Steroids in Conjunction with Chemotherapy in Tuberculosis. Transactions of the 16th Conference on the Chemotherapy of Tuberculosis. Veterans Administration-Armed Forces (Feb. 1957).

York. These are included by courtesy of Dr. Margaret H. D. Smith who heads this department.

METHODS

ON ADMISSION, all patients were started on isoniazid in doses of 10 to 20 milligrams per kilogram of body weight, divided into 3 or 4 doses daily. They also received 500 milligrams of para-aminosalicylic acid (PAS) per kilogram of body weight daily, in 4 divided doses. Streptomycin was administered only to those with miliary or meningitic infections. The amount of this drug varied with the age of the patient and the severity of the disease.

The only steroid used in this study was prednisone (Meticorten®), 1 to 2 milligrams per kilogram of body weight daily, in 4 doses. In most cases, after 4 weeks the hormone was given for only 3 or 4 consecutive days each week and then the dosage was tapered off to none at 6 weeks. Interrupted therapy was continued for longer periods when discontinuance of the drug was followed by a rebound with higher fever and disturbing symptoms. During steroid treatment, Terramycin® was substituted for PAS in order to provide more versatile antibacterial coverage and continue prevention of emergence of resistant strains of tubercle bacilli.

RESULTS

The value of steroid therapy in this study was judged by the following criteria:

1. *Clinical response*: Abatement of fever, increase in appetite and weight gain, decrease in cough and dyspnea, well-being, normal behavior and activity, and improvement in physical signs.
2. *Changes in chest x-rays*: Reduction of abnormal shadows significantly earlier than expected with chemotherapy alone.
3. *Laboratory findings*: Return of spinal fluid components, erythrocyte sedimentation rates, and hemograms to normal values.

Using these criteria, we classified our results as follows:

1. *Miliary tuberculosis*: Two of the children responded so favorably in every respect to be considered as successfully treated. In 3 cases the clinical response was satisfactory but improvement in the x-ray findings was not appreciably hastened. In the remaining patient, we could observe no added benefit from the steroid.
2. *Tuberculous meningitis*: All three children survived, but one became blind and later showed minimal improvement in vision. In the other two cases, the cures were considered as accelerated and complete.
3. *Progressive primary pulmonary tuberculosis*: One child was classified by all criteria as successfully treated. A second child showed gratifying clinical improvement only. There was no noticeable benefit from steroid therapy in the third patient.
4. *Pleural effusion*: The only patient studied was judged a therapeutic success.
5. *Tuberculous endobronchitis*: The 2 Bellevue Hospital cases demonstrated by bronchoscopy the very favorable effect of prednisone in reducing the pathologic changes in the bronchi. Rapid shrinking of the associated pulmonary lesions was noted in concomitant chest x-rays.

In summary, steroid treatment of our 15 studied cases resulted in success in 8, only clinical improvement in 5 cases, and failure in the remaining 2 cases.

We have selected 6 representative cases for detailed presentation, the first 4 being from Essex County Hospital.

CASE ONE

A 27 month old boy was admitted on May 8, 1957. His father had died of tuberculosis in March, 1957. The presenting symptoms were cough, weight loss, lethargy and fever of 2 weeks' duration. He was a malnourished infant weighing only 17 pounds. There was dullness and prolonged expiration over the lower lobe of the right lung. The liver edge was palpated 3 to 4 centimeters below the costal margin. A tuberculin patch test was negative on admission but converted to positive 46 days later. The blood count showed 3,600,000 red blood cells per cubic millimeter of blood and 70 per cent hemoglobin. The erythrocyte sedimentation rate was 62 millimeters for the first hour; 7 weeks later the rate declined to 43 millimeters and after another month repeated determinations were in the normal range. The gastric fluid was repeatedly negative for acid-fast bacilli.

Immediately after Meticorten® was begun, the child became afebrile and his appetite improved. When intermittent treatment started, the fever rose to 104 but returned to normal when the drug was resumed. Although steroid therapy is considered to be detrimental during an attack of varicella, this infant showed no ill effects when the drug was continued during the disease. He gained 15 pounds in 11 months (Figure 1).

X-ray findings: On admission, both lungs were

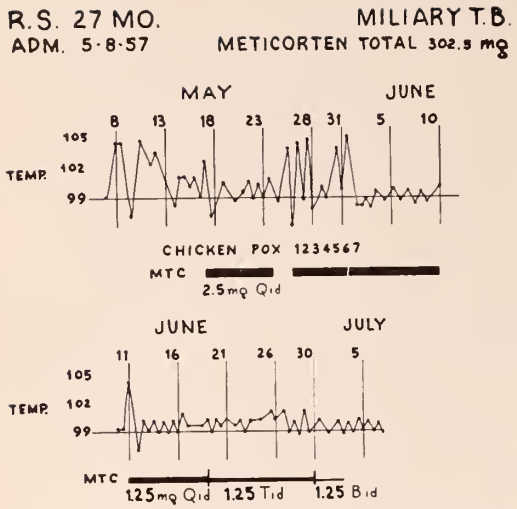


Figure 1. Control of fever with Meticorten® (MTC).

diffusely mottled with miliary lesions many of which were already coalesced. There were areas of confluent bronchopneumonia in the right upper and middle lobes and the left upper lobe. Six weeks later there was considerable clearing of the peripheral lung fields and only a small confluent infiltrate in the right paracardiac area. There was further moderate clearing of both lungs in the next 3 weeks and a normal picture 7 months later except for faint bilateral mottling and slight widening of the upper mediastinal shadow (Figure 2a-b).



Figure 2a. Admission film showing diffuse miliary tuberculosis with confluent bronchopneumonia in the right upper and middle lobes and the left upper lobe.



Figure 2b. Six weeks later, under Meticorten® therapy, there has been considerable clearing of the miliary lesions and resolution of the pneumonic areas.

CASE TWO

A 3 year old boy was admitted on July 15, 1957. There was no history of known exposure to active tuberculosis. There was cough, fever, weight loss and abdominal pain for one month prior to admission. The only positive physical findings were cervical adenopathy and hepatomegaly. The tuberculin patch test was positive. In the blood count, there was 70 per cent hemoglobin and 3,100,000 red blood cells per cubic millimeter. Erythrocyte sedimentation rate which was 55 millimeters, in the first hour, declined to 17 two months later and then remained within normal limits. The gastric fluid was repeatedly negative for acid-fast bacilli.

The patient became drowsy and began to vomit two weeks after admission. Lumbar puncture was then performed. The spinal fluid contained 1,320 white blood cells per cubic millimeter, 50 per cent being polymorphonuclear cells. No sugar was present and the protein was 194 milligrams per 100 cubic centimeters. Three weeks later, the spinal fluid showed 78 lymphocytes per cubic millimeter, 40 milligrams of sugar and 29 milligrams of protein per 100 cubic centimeters.

X-ray findings: The lungs were seen to have a diffuse miliary infiltration and the upper mediastinum was widened. The next view, 24 days later, revealed some clearing and within 4 weeks more the parenchymal shadows diminished considerably. Six months later, the only distinct evidence of pulmonary disease was an enlargement of the right hilum and the still widened mediastinum.

Clinical course: At first, spiking temperature continued despite steroid therapy while the patient gained 10 pounds and developed a "moon face." Therapy was suspended for a week. When resumed, the temperature rapidly returned to normal and remained so thereafter except during a few attacks of upper respiratory infection. The appetite was increased and there was a weight gain from 34¼ to 47¼ pounds in 10 months.

CASE THREE

A 21 month old boy was admitted on May 16, 1957. The source of his tuberculosis was a paternal aunt. Four days before admission, he exhibited dysphagia, irritability mixed with lethargy, and cough. The tuberculin patch test was markedly positive. The pharynx was injected and covered with a purulent exudate. The sensorium was depressed. There was moderate nuchal rigidity and both Kernig and Brudzinski's signs were positive.

The initial spinal fluid examination revealed 100 white blood cells per cubic millimeter, 50 per cent being polymorphonuclear cells. The sugar was 33 milligrams and the protein 131 milligrams per 100 cubic centimeters. Forty days later, these values had changed to 75 white blood cells of which 95 per cent were lymphocytes; the sugar had increased to 40 and the protein was 145 milligrams. The hemogram contained 4,500,000 red blood cells and 15,000 white blood cells per cubic millimeter and 70 per cent hemoglobin. In the blood smear, the red blood cells showed moderate achromia and the differential count showed a shift to the left. Erythrocyte sedimentation rate was 28 millimeters in the first hour. After 3 months, the rate was always within normal limits. The gastric fluid was consistently negative for acid-fast bacilli.

Rigidity of the neck and lower extremities gradually lessened in the first month. Six weeks after admission, it was noted that the patient was blind. Ophthalmologic examination revealed a primary optic atrophy. Five months later, he began to talk and walk and seemed to regain some vision as he avoided obstacles in his path. There were no other residual defects. The temperature curve indicated control of fever during steroid administration and a rebound when it was not given. Both the appetite and the hemoglobin increased during the prednisone administration period, and the weight gain was 11 pounds in a year.

CASE FOUR

A 13 year old girl was admitted on December 30, 1956. Source of her disease was unknown. In September, 1956, a routine school chest roentgenogram revealed pulmonary disease. A tuberculin patch test was then done and found to be positive. At this time, she began to have a productive cough and became dyspneic. Following this there was irregularity of menstruation and loss of weight. Subcrepitant rales were heard over the right lower lobe.

The hemogram was normal but the erythrocyte sedimentation rate was elevated to 30 millimeters in the first hour. All gastric fluid examinations were negative for acid-fast bacilli.

X-ray findings: On admission there was a pleural effusion at the right base, thickening of the horizontal fissure, and an exudative infiltration in the right middle lobe. A lateral view 27 days later showed that most of the pleural changes were anterior while the posterior space had cleared. There was significant regression of the effusion and the paracardiac infiltration 6 weeks after admission. Two and one half months later, the only sign of the pleural involvement was a veiled appearance of the right base. The parenchymal lesion was now discrete; the fissure was no longer visualized. After 4 more months, the right hemithorax was clear except for mesial linear markings.

Clinical course: The patient improved rapidly and progressively with a weight gain from 90 to 123 pounds in 9 months.

In the following two cases, tuberculous endobronchitis was diagnosed by bronchoscopy. Their progress under steroid therapy was studied by repeated bronchoscopic examinations and correlated chest x-rays.

CASE FIVE

A 2 year old boy was admitted to Bellevue Hospital on January 11, 1958. Mantoux test with 1 to 1000 Old Tuberculin (10 tuberculin units) was strongly positive with induration measuring 22 millimeters. The initial gastric fluid culture was negative but a second contained 1 colony of acid-fast bacilli which were fully sensitive to isoniazid and streptomycin. Despite supposedly adequate doses of isoniazid (20 milligrams per kilogram of body weight) and para-aminosalicylic acid (one half gram per kilogram of body weight), the early prominent lesion in the right hilum became overshadowed by a progressive infiltration in the left upper lobe. Bronchoscopy 8 weeks after chemotherapy was started, showed some edema and redness of the right upper lobe orifice and more in the left upper lobe orifice. The orifice of the anterior segment of the left upper lobe was almost completely occluded by the same process.

Steroid therapy was started two days later and after only 5 days, a second bronchoscopy revealed an almost normal right upper lobe orifice. The two involved left upper lobe orifices had markedly increased patency. At the same time, the x-ray shadows in the left upper lobe had shrunken considerably and were confined mostly to the hilar area.

CASE SIX

A 19 month old girl was admitted to Bellevue Hospital on January 16, 1957, eight days after a Mantoux test was found to be positive. Gastric fluid, withdrawn on the second day, cultured out 25 colonies of acid-fast bacteria. Thereafter, all gastric fluids were negative except for one colony found three weeks after admission and 15 days after chemotherapy was begun.

Initial chest x-ray showed bilateral hilar enlargement apparently due to nodal involvement. Bronchoscopic findings two weeks later were: nar-

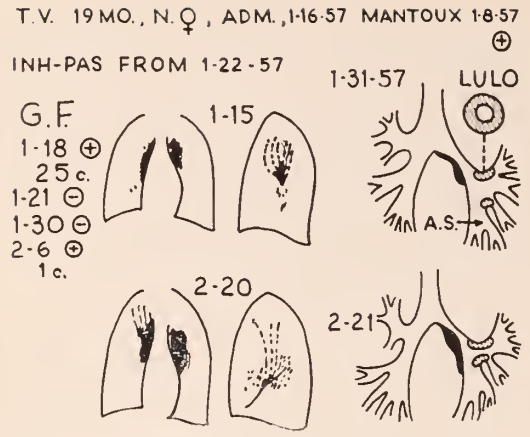


Figure 3a. Graphic representation of roentgenographic and bronchoscopic findings in a case of tuberculous endobronchitis. Adequate doses of isoniazid (INH) and para-aminosalicylic acid (PAS) did not prevent the spread of the parenchymal infiltration and progressive narrowing of the left main bronchus by external pressure and of the left upper lobe orifice (LULO) and the anterior segment orifice (A.S.) by mucosal edema. Culture from the gastric fluid (G.F.) was positive at onset and again 19 days later.

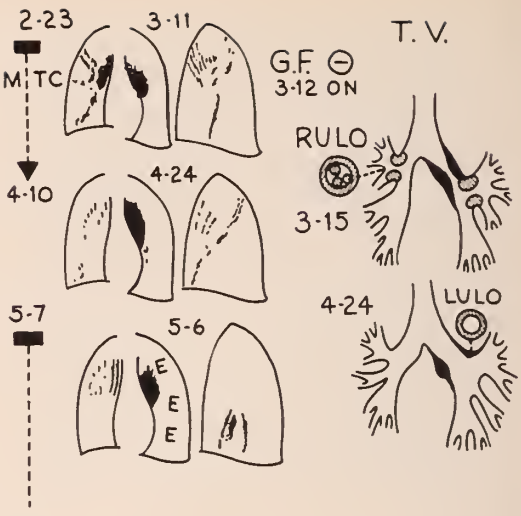


Figure 3b. Two weeks after start of steroid therapy, right lung infiltration increased with blockage of right upper lobe orifice (RULO) by granulation tissue in the lumen. Emphysema (E) appeared in the left lung after prednisone was discontinued.

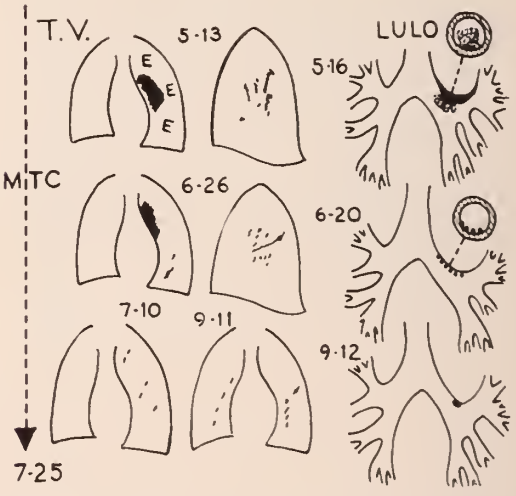


Figure 3c. The left lung emphysema was shown to be due to increased obstruction of LULO by granulation tissue. Both pulmonary and bronchial pathology regressed with resumption of steroid administration.

rowing of the lumen of the left main bronchus by external compression. Distally, secondary orifices were narrowed by inflammation and edema of the bronchial mucosa, especially in the orifice of the anterior segment. In 5 weeks, the pulmonary infiltration had increased bilaterally coincidental with the progressive narrowing of the bronchial orifices. Within 3 more weeks, the tuberculous infiltrate had spread in the right upper lobe. At the same time, increased narrowing of the right upper lobe orifice was seen and there was granulation tissue within the bronchus. This new development occurred more than 2 weeks after steroid therapy was started. However, 40 days later the right upper lobe orifice was normal and there was almost complete regression of the right lung infiltrate. The left upper lobe orifice had a normal mucosa but slight narrowing of the lumen by external pressure persisted.

Steroid administration was interrupted at 6 weeks but was resumed 4 weeks later when x-ray revealed emphysema of most of the left lung. This apparently resulted from a progressive narrowing of the left upper lobe bronchus by a new formation of granulation tissue within its orifice. By an oversight, the second course of prednisone was not interrupted for more than two and one half months. However, there were no ill effects and the bronchial and parenchymal lesions regressed more rapidly and completely than in comparable cases. Less than 2 months after the steroid was finally discontinued, only a small mucous polyp was seen in the left upper lobe orifice. This was easily removed by surgery through the bronchoscope. The chest x-ray was now almost completely clear. (Figure 3a-b-c).

This small group of children with various forms of tuberculosis responded to treatment with corticosteroids in about the same way as reported by numerous observers. The value of this therapy was significant in some forms but less so in others.

In tuberculous meningitis, these steroids have been responsible for a marked lowering

of mortality, especially in the late cases, and for a decrease in disabling sequelae in the survivors. They have effectively reduced obstruction to the flow of cerebrospinal fluid[7] by basal exudate with a lessening of intracranial pressure. Thus irreversible hydrocephalus and cerebral endarteritis have been minimized. Amblyopia due to chiasmatic arachnoiditis showed satisfactory improvement particularly in peripheral vision. Heymann[8] reported that adrenocorticotropin given in advanced cases of tuberculous meningitis had reduced the mortality from 33 to 20 per cent and the incidence of sequelae by 50 per cent.

The corticosteroids have been found valuable in treating early pulmonary tuberculosis in which most of the infiltration consists of exudative elements as in miliary and progressive primary tuberculosis. They afford more rapid relief of symptoms and recession of lung changes. Spink[2] states that, at the University of Minnesota, all cases of miliary tuberculosis which do not respond satisfactorily to 7 to 10 days of chemotherapy are given steroid therapy.

In tuberculous pleural effusion, the steroids have been of particular value. Symptoms improved much more quickly and whereas the average case treated with chemotherapy alone continued to show pleural fluid for 48 days, with the addition of steroids, there was no fluid after 4 to 14 days.[7]

Endobronchitis associated with primary tuberculosis in children has shown a dramatic response to steroid therapy in about one-third of the cases treated recently at Bellevue Hospital. About half of the remainder showed a questionable response but none were made worse by this form of treatment. Lincoln's 156 cases did not evidence a favorable influence from antimicrobial therapy and therefore she advocates exploring further the use of steroid treatment[9] because, theoretically at least, it should have a good effect on the early stages.

SUMMARY

1. A group of 15 children with primary tuberculosis in various forms were treated with antimicrobial drugs plus Meticorten® (prednisone) and the results are reported.

2. There is evidence that steroids have benefited those patients with miliary tuberculosis, meningitis or endobronchitis. There were no important unfavorable side-effects caused by the hormones in this group.

3. Further investigation of the use of the steroids in the treatment of childhood tuberculosis is definitely justified from the experience already accumulated.

4. There should be no fear of using the corticoids in the treatment of primary tuberculosis in children as long as the infecting organisms are known to be sensitive to the specific therapy being used.

7. Smith, Margaret, H. D.: Personal communication.

8. Heymann, Seymour: Treatment of Tuberculous Meningitis. Transactions of the 8th International Congress of Paediatrics, Copenhagen (July 1956).

9. Lincoln, E. M., Harris, L. C., Bovornkitti, S. and Caretero, R. W.: Endobronchial Tuberculosis. American Review of Tuberculosis and Pulmonary Diseases, 77:1 (Jan. 1958).

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Fats vs. Heart Disease

Because decisive proof of a possible connection between cardiovascular illness and the nutritional role of fats is lacking, major changes in the American diet are not recommended at this time. Dr. Paul L. Day, chairman of the Committee on Fats of the National Academy of Sciences-National Research Council, points out that more research is needed to determine which fats are nutritionally desirable and which, if any, are undesirable.—*Modern Medicine*, August 15, 1958.

Robert A. Kuhn, M.D.

Morristown

The Revolution Produced by Cerebral Angiography in Management of the Patient with "Stroke"

Considering the diagnostic value of cerebral angiography, it is hard to account for our inertia in using it. As Dr. Kuhn here points out, it can lead to effective treatment in many cases that would otherwise be waste-basketed as "strokes."

The past few years have witnessed striking changes in the medical management of cerebrovascular disease, particularly in reference to treatment of its complications. Not too many years ago, it was sufficient for the family physician to recognize that the patient was suffering from "stroke." Causal factors underlying the stroke were of no particular significance, for at that time there was little hope of effective therapy.[1,2] This is no longer true. Today, accurate diagnosis of precise factors underlying a "stroke" has become a vital requisite[1,3,4] before effective treatment can be undertaken.

In the past, it has been customary to classify a patient with cerebrovascular accident in one of several broad clinical diagnostic groups, such as "brain hemorrhage," or "cerebral thrombosis." These misleading categories are not only uninformative but inadequate for patients today with these particular neurologic problems. Advances in medical and neurosurgical therapy have made a determination of the precise anatomic lesion a primary consideration in each case. It has thus become imperative that we comply with the first essential of adequate therapy for every patient with "stroke": a focal, anatomic delineation of the cause. Only when this important datum has been ascertained can modern treatment for the victim of sudden hemiplegia or "apoplexy" be properly initiated.

Concepts of mechanisms involved in precipitating a brain "stroke" are now in a process of marked evolution. The old clinical terminology which found expression in the time-honored "diagnosis" of cerebral thrombosis and cerebral hemorrhage has, concomitantly, given way to more precise descriptions of factors operative in producing sudden cerebral dysfunction. This fundamental change has been wrought largely through the development of safe cerebral angiography.[5] Increasing use of this technic and of ancillary diagnostic studies, has made it clear that the term "stroke" is a misnomer[6] blanketing a multitude of lesions

1. Millikan, C. H.: A Classification of Cerebrovascular Diseases. *Ad hoc* Committee, Nat. Inst. Neurol. Dis. and Blindness, P.H.S. Neurology, 8:395 (May 1958).
2. Murphy, J. P.: Cerebrovascular Disease, The Year Book Publishers, Inc., 1954. Foreword.
3. Webster, J. E. and Gurdjian, E. S.: Responses to Digital Carotid Artery Compression in Hemiplegic Patients. Neurology, 7:757 (1957).
4. Davidoff, Leo: Intracerebral Hemorrhage Associated with Hypertension and Arteriosclerosis. J. Neurosurg., 15:322 (1958).
5. Segelov, J. N.: Safe Angiography, J. Neurosurg., 13:567 (1956).
6. Kuhn, R. A.: Diagnostic Considerations in Patients with Stroke. *Geriatrics*. In Press.

having in common only their capacity to produce relatively sudden interference with brain function. The following new data are offered in support of these conclusions:

First, occlusive cervical carotid artery disease is one of the important causes of "stroke."[7] It is probable that as many as one of every four hemiplegias is a direct or indirect result of arterial obstruction in the neck. It has been known for some time[2] that about 60 per cent of patients with autopsy-verified brain infarcts and with presumed clinical cerebral "thrombosis" show no discoverable *cerebral* vessel occlusion. It is highly likely that most of these patients possessed unsuspected segmental carotid disease in the neck which eventually produced an ischemic cerebral infarct. A large proportion of patients with ischemic brain infarct, who had been diagnosed in the past as having cerebral thrombosis have, in reality, been the victims of "stroke" due to progressive arterial occlusive disease in the neck.[8]

UNFORTUNATELY, there are no neurologic features which unequivocally distinguish a "stroke" due to carotid occlusion in the neck from any other non-hemorrhagic "stroke." In other words, a common "stroke," in the absence of intracranial bleeding, may be due either to cervical carotid occlusion or to cerebral artery occlusion or insufficiency resulting from other factors. The only certain way to distinguish these is through cerebral arteriography.

Of what practical importance to the patient is the information thus gained?

Arterial surgery of increasing complexity has become almost commonplace in recent years. Many of its brilliantly successful applications have been in correction of segmental arterial disease of the aorta and more peripheral vessels. Segmental occlusive arterial disease at the carotid bifurcation, despite its strategic location and unfortunate sequelae, is but one aspect of a disease which may, for example, also affect the femoral artery in the thigh, or perhaps the origin of the left coronary artery. Arterial reconstructive or by-pass procedures in the neck create certain special neurosurgical problems; but these are not unsurmountable. It is obviously desirable to restore normal flow volumes of arterial blood to the brain. Surgical measures to accomplish this for victims of "stroke" have been increasingly successful as technics have become more standardized.[9,10,11] Tentative conclusions can be drawn from neurosurgical therapy to date for this type of "stroke." Time is apparently a crucial factor. Reversibility of neurologic signs and symptoms increases proportionately to the rapidity with which adequate arterial flow volumes to the brain are restored, emphasizing the need for prompt diagnosis by angiography. Clinical improvement of "stroke" victims following surgery is reported more frequently after prompt elimination of partial arterial occlusions than after those demonstrated to be complete,[12] and perhaps long-standing. Thrombo-endarterectomy and certain by-pass technics have given fair results, but it seems probable that, eventually, arterial prostheses will be found to function best in this location, as has been the experience with these synthetic materials in other locations.

Second, certain "stroke" patients with proved cerebral artery thrombosis or insufficiency show dramatic sustained remission of advancing neurologic disease when placed on anticoagulant medication.[13,14] Unfortunately, a differential diagnosis of a "stroke" due to this type of lesion is sometimes hard to make using clinical criteria alone. A slowly growing brain tumor or an intracranial arteriovenous anomaly may produce signs and symptoms

7. Fisher, M.: Occlusion of the Carotid Arteries. Arch. Neurol. & Psychiat., 72:187 (1954).

8. Webster, J. E., Gurdjian, E. S. and Martin, F. A.: Carotid Artery Occlusion. Neurology, 6:491 (1956).

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10. Lyons, C. and Gulbraith, J. G.: Surgical Treatment of Internal Carotid Artery Occlusion. *Geriatrics*, 13:1 (1958).

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12. Symposium on Carotid Artery Thrombosis. Clin. Neurosurg., 3:142 (1956).

13. Fisher, C. Miller: Anticoagulants in Cerebral Thrombosis. Neurology, 8:311 (May 1958).

14. Millikan, C. H., Siekert, R. G. and Whinant, J. P.: Anticoagulant Therapy in Cerebral Vascular Disease—Current Status. JAMA, 166:587 (1958).

that are identical, at least in initial stages, with those produced by arteriosclerotic cerebral lesions. Cerebral angiography shows persistent non-filling of one or more vessels in cerebral artery occlusion; whereas characteristic alterations are noted in arterial patterns for the other conditions. Since the type of therapy differs greatly for each of these, or for others not mentioned, it is mandatory, that a precise diagnosis be swifty established.

For the patient with brain hemorrhage, cerebral angiography is indispensable for accurate diagnosis.[4,15] For many years mortality rates have remained above 95 per cent [16] in patients with so-called "spontaneous cerebral hemorrhage" who were treated expectantly.[17] These are persons whose illness constitutes "the fourth most common cause of death in the United States."* Yet early precise diagnosis in these cases, coupled with adequate neurosurgical therapy, can drastically lower the death rate. A recently reported series [4] of elderly patients with massive brain hemorrhage were carefully evaluated through cerebral angiography, and surgical therapy used as indicated. These patients showed a mortality rate of only 50 per cent. While this could hardly be termed a low death rate, still it is incomparably better than the former almost universal fatality, and is a giant step toward improved treatment.

It has been pointed out in a previous communication by the author [6] that the clinical diagnosis of cerebral hemorrhage usually has ill-defined boundaries. Bleeding within the head may occur because of different lesions, each of which presents markedly differing problems in management and treatment. Intracerebral hemorrhage due to rupture of an arteriosclerotic vessel makes up one group. Others include: patients with bleeding intracranial aneurysms; hemorrhage in an unsuspected brain tumor; rupture of an arteriovenous anomaly; or perhaps cerebral bleeding as a manifestation of a generalized disease process. Accurate diagnosis can be accomplished, with varying degrees of difficulty, in all of these cases. In a few a precise diagnosis may be self-evident; and in a small residue of cases no definitive therapy will be of avail. In the vast majority, however, effective treatment will depend solely upon the discovery of the exact nature and location of the lesion which has produced bleeding, together with the extent of the clot. This information is obtained in most instances from cerebral angiography.

The fact must be faced that clinical neurologic evaluation of a patient with "stroke" cannot be relied on to disclose the precise lesion which produced it. Yet, an exact diagnosis is essential. Recent advances in therapy have made such knowledge indispensable. The following few cases of perfectly "ordinary stroke" illustrate the fallacy of clinical neurologic estimates, the ease of evaluation by cerebral angiography, and the utter dependence of proper therapy upon establishment of a focal diagnosis.

CASE ONE

This 72-year old author had been in excellent health when she suddenly complained of brief recurring weakness in her right arm and leg. She was having slight difficulty speaking. These "spells" returned three times in the space of one hour. When her physician arrived shortly thereafter she was asymptomatic. Examination by him revealed an alert patient with a blood pressure of 178/100. The only other pertinent observation was that she showed an unusual (for her) sluggishness of her speech. Four hour later, she suddenly collapsed to the floor and was rendered completely mute, with total paralysis of her right upper and lower limbs. In thirty minutes, slow recovery of these neurologic deficits began and continued as the patient was hospitalized. Admission diagnosis was that of repeated "strokes" involving the left brain. She was seen in consultation one day after admission.

Examination: She was an alert, confused woman whose speech was slow and occasionally stuttering. Blood pressure was 160/100. There were no signs of cardiac failure. Although she had considerable articulatory difficulty, she followed simple commands well. The carotid pulsations seemed equal. There was moderate resistance to passive

*U. S. Public Health statistics, 1948.

15. Silver, M. L.: Management of Intracranial Bleeding. JAMA, 163:1097 (1957).

16. Aring, C. D. and Merritt, H. H.: Differential Diagnosis Between Cerebral Hemorrhage and Cerebral Thrombosis. Arch. Intern. Med., 56:435 (1935).

17. Zimmerman, H. M.: Cerebral Apoplexy: Mechanism and Differential Diagnosis. N. Y. St. J. Med., 49:2153 (1949).

flexion of the head on the neck. She had a right spastic hemiplegia. There were no voluntary movements of these limbs, although the lower limb would withdraw from noxious stimuli. Right tendon reflexes were hyperactive and there was a strongly positive right Babinski sign, and absent right abdominal reflexes. Stereognosis was lacking in the right hand.

Skull x-rays were within normal limits. Electroencephalography was not done.

Clinical Diagnosis: Possible left cervical carotid occlusive disease, with left cerebral ischemia, recurrent.

Serial left carotid angiography three days after hospital entry disclosed roughening of the intracranial portion of the left internal carotid artery, and a small berry aneurysm at the origin of the left anterior cerebral artery.

Final Diagnosis: (1) Arteriosclerosis, intracranial portion of left internal carotid; and (2) berry aneurysm, left anterior cerebral artery.

Course: Gradual reduction of the severe spasticity and return of voluntary muscular function occurred in the period following angiography. Within five days, she was able to walk unaided. A few days later she showed little external evidence of her recent "stroke." Blood pressure remained high. Gradual surgical occlusion of the left internal carotid in the neck was considered but rejected because of her age, her unfavorable response to a Matas test, and her husband's reluctance to permit surgical measures. Hemiplegia recurred a few months after discharge from the hospital, and, 5 months later, she was aphasic and being cared for in a nursing home.

Even with full knowledge of the actual lesion there are no clues in the history of present illness, examination of the patient, or course of later events which might have indicated the correct anatomic diagnoses. Clinically, differential diagnosis might well have included "spasm" of cerebral vessels, cerebral thrombosis, cerebral hemorrhage, or even carotid occlusive disease. The particular combination of lesions actually discovered could hardly have been seriously entertained as diagnoses prior to arteriography, for they were responsible for no specific symptoms or signs that might be considered characteristic of their presence. Findings in this case are unique for the demonstration of intracranial lesions not only totally unsuspected, but probably existent for a considerable number of years before they were productive of symptoms. *This patient is a dramatic example of the virtual impossibility, in some instances, of establishing a diagnosis without angiography.* It in no way detracts from the importance of these considerations that, in this case, the combination of multiple lesions of a dominant hemisphere in a 72-year old patient precluded any but supportive therapy.

CASE TWO

This 69-year old male had experienced, over the past $4\frac{1}{2}$ years, a series of "strokes" which superficially resembled fainting or syncopal episodes. He would suddenly collapse to the ground, lose consciousness, and then promptly recover. As these attacks became more frequent their character changed somewhat. Gradually increasing partial paralysis of the lower limbs came to be occasionally coupled with loss of ability to speak or recognize verbal stimuli. During the weeks just prior to hospital entry he experienced great difficulty getting up and down stairs, and would frequently "collapse at the knees."

Examination: This alert, elderly man walks in slow, stumbling fashion and grasps at nearby furniture in an effort to steady himself. The normal rhythm of muscular coordination in his lower limbs is seriously disrupted, and he moves in jerky unsure fashion. Tendon reflexes are asymmetrical in the lower limbs and an inconstant left Babinski sign is obtained. Carotid artery pulsations seem to be stronger on the left. Electroencephalography disclosed bursts of delta slowing in the left anterior temporal region.

Clinical Diagnosis: Possible left cerebral tumor. Possible cervical carotid disease.

Serial left carotid angiography showed a huge, coiled mass of greatly dilated cerebral vessels replacing the anterior pole of the left temporal lobe. This was an arteriovenous anomaly the size of a small orange.

Final Diagnosis: Left temporal lobe arteriovenous malformation.

Course: The position of this arteriovenous mass precluded operative resection. Complete cerebral angiography disclosed that other vascular intracranial channels were normal. Using customary precautions, the left carotid artery was surgically ligated and divided to reduce the arterial pressure-head feeding the mass. Postoperative recovery was without incident. It is now a year since ligation was performed. The "strokes" stopped immediately and no further memory lapses have occurred. Equilibrium returned rapidly to normal and stair walking is now no problem. All abnormal neurologic signs have long since disappeared.

The "strokes" manifested by this patient were, in all likelihood, due to the compressive and percussive effects of the pulsating vascular anomaly. Occasionally these lesions can be safely removed *in toto*—although in this instance the risk of producing aphasia by inadvertent temporal lobe damage was considered

too great. We did accomplish satisfactory reduction of the arterial pressure-head being transmitted through the enlarged carotid artery feeding the lesion. This was done by ligating that vessel. This procedure was effective in abolishing symptoms and eliminating the neurologic signs.

It seems probable that this lesion could not have been discovered, nor effectively treated, unless cerebral angiography had been done.

CASE THREE

This 64-year old man has been "feeling poorly" for several months but could not be pinned down to any specific complaint. Two weeks ago he awakened with double vision. The same morning he "broke out in a cold sweat" and his walk became unsteady. Severe dizzy spells occurred. He soon noted that his left face was drooping and felt numb. These sensations then spread to the left upper limb, and he began to limp. Apparently he had developed a left hemiparesis. There was no loss of consciousness at any time.

Examination: This unsteady male shows flattening and sagging of the left face. As he walks the left lower limb is circumducted; flexion of the thigh at the hip is decreased; and extra steps are taken with this leg when he is requested to turn. He is unable to walk tandem. Moderate droop and posturing occurs in the outstretched left upper limb. There is increased muscle resistance in both left limbs and a prominent left Babinski sign is elicited. Sensory changes are denied. Pupils are equal. There is a left medial rectus palsy and subjective double vision. The left facial paresis is accompanied by considerable hyperesthesia involving particularly the lower face. Tongue and pharyngeal function is normal. X-rays of the skull and brain wave recordings are not abnormal.

Clinical Diagnosis: Right cerebral thrombosis.

Serial bilateral carotid angiography disclosed normal intracranial arterial patterns, but marked incomplete obstruction of each internal carotid artery at its point of origin in the neck.

Final Diagnosis: Incomplete bilateral obstruction of the internal carotid arteries in the neck due to segmental arterial disease.

Course: Although neurologic signs were confusing in regard to localization, it was thought that the right cerebral hemisphere was maximally involved. Right thrombo-endartectomy at the carotid bifurcation was carried out under general anesthesia. A typical atheromatous plug was found to be occluding the internal carotid artery. After isolation between arterial clamps, the atheroma and attached intima was shelled out in one piece through a transverse incision and the vessel resutured. Recovery was uneventful. The patient was placed promptly upon anti-coagulant medication. During the next several weeks there occurred slow but steady improvement in neurologic function. The instability of gait cleared; the facial paresis disappeared; and the diplopia grew less marked. Within a month of surgery his neurologic status was normal and has been maintained so for the past year.

The state of the cerebral arterial circulation in case 3 must have been marginal for many months. It is probable that there was obstructive disease in the basilar artery similar to that in both cervical carotids. Under these circumstances, production of ischemia of nervous tissue might be anticipated far removed from the sites of obvious obstruction in the neck to arterial flow. No doubt many (or perhaps all) of his symptoms and signs were referable to brain stem dysfunction. When circulation in this area was raised from marginal to adequate by increasing cervical carotid inflow, normal function was restored. It has not yet been felt necessary to attempt repair of the left carotid bifurcation, although that may be eventually required.

CASE FOUR

During the past 5½ years, this 50-year old salesman experienced at least three episodes of sudden "weakness" of the right arm and leg. These spells were diagnosed as "light strokes" by several physicians. A typical attack came on without warning, and within minutes he would "find my right arm hanging at my side and I couldn't move it." There were no symptoms suggestive of impaired sensibility in the affected limb. He would simultaneously develop a veering and unsteady gait. The period of recovery following each stroke grew longer with each attack. Recuperation was not as complete. It had taken almost a month for him to become ambulatory after the second episode; and after the third he had retained a permanent limp, from which he was still recovering. No loss of consciousness had ever occurred. He had had no headaches. Repeated medical examinations had failed to disclose any physical abnormality except for a moderately elevated arterial pressure.

Examination: The patient looked considerably older than his age of 50. He had a typical hemiplegic gait, with slight circumduction of the affected thigh and somewhat accentuated plantar droop of the foot as he stepped out. Rhythmic alternating movements were poorly performed with the right hand and fingers, and there was striking loss of both position sense and manual dexterity in them. Typical alterations in muscle resistance were noted, the tendon reflexes being increased in the right limbs. Unsustained ankle and knee clonus was evoked on that side together with a markedly positive Babinski sign. There was no

evidence of increased intracranial pressure, and none of aphasia. To palpation, the thrust of the left common carotid pulsation seemed decreased in comparison with the right.

Clinical Diagnosis: Right hemiplegia due to left "cerebral ischemia," cause unknown.

Serial left carotid arteriography showed a striking arterial picture. The left anterior cerebral artery, three times normal size, led to a nest of tangled arteries on the upper, medial edge of the right frontoparietal lobe. These findings were characteristic of arteriovenous malformation of the brain.

Final Diagnosis: Arteriovenous anomaly of the right frontoparietal brain.

Course: Craniotomy was done several days following angiography. No attempt was made to resect the entire lesion because of its critical location. The major arterial vessels feeding the pulsating mass were doubly clipped, and satisfactory partial collapse obtained, together with cessation of pulsation. Recovery from surgery was not prolonged. On the fifth postoperative day the patient was up in a chair exercising his arm. Over the next 2 months, the previous steady deterioration of neurologic function was reversed. For the first time, gradual improvement was noted in both his gait and in the functioning of his right arm. Reexamination six months following operation disclosed a still-hesitant but much less hemiparetic walk; return of customary dexterity to rapid finger-hand movements; and disappearance of the chronically positive Babinski response.

Utilizing clinical criteria alone, signs and symptoms in this patient seemed identical to those in others who develop a perfectly "ordinary" hemiplegia. The history of recurrent attacks of paralysis might seem unusual for cerebral artery insufficiency due to arteriosclerosis, but not enough so to be diagnostic of the actual lesion. It is probable that the true cerebral lesion would have remained undiscovered—and untreated—if cerebral angiography had not been performed.

CASE FIVE

Two weeks prior to consultation examination this 62-year old executive awakened with a sensation of unaccustomed heaviness in his left upper limb. He found to his surprise that his left leg would not sustain his weight. Within the hour numbness and "pins and needles" sensations began in the left hand, and voluntary motion in it grew increasingly weak. His physician prescribed bed rest and medication for high blood pressure. Over the next 48 hours, slow improvement in the hemiparesis occurred. He gradually became able to get around again under his own power. One week after the first "stroke," another struck him as he was preparing to eat his meal. This time total paralysis of the left arm and profound weakness of the left leg ensued within several minutes. He was then admitted to the hospital, mainly because he had become too great a nursing problem for his wife to handle at home.

Examination: He was a moderately obese, apprehensive, plethoric male sitting in bed with his left upper limb extended limply by his side. No voluntary movements in it were noted during the interview. The left lower face was flattened and sagging slightly. The resting position of the left lower limb was abnormal, there being external rotation of the thigh, leg and foot. He was unable to extend his left arm at right angles at the shoulder, and muscle strength at the apex of the limb had vanished except for feeble flexion movements of the fingers. There was slight hypesthesia and hypalgesia over the entire left side of the body, but no loss of position sense or stereognostic ability. Deep reflexes were hyperactive in the left limbs and a left Babinski sign was present. He was unable to walk.

Clinical Diagnosis: Probable right cerebral artery occlusion.

Serial right carotid angiography showed excellent filling of the common and external carotid arteries, but there was complete occlusion of the internal carotid at the bifurcation, with some filling of intracranial vessels by reflux.

Final Diagnosis: Right cervical carotid disease with complete occlusion.

Course: Surgical reconstruction of the bifurcation, with restoration of blood flow through the right internal carotid artery, was accomplished several days later. A typical stony atheroma and a recent partly-organized clot were removed from the artery. He was up in a chair the day after operation and began to show increasing voluntary power in the paretic limbs within another twenty-four hours. Since that time there has been almost complete return of function. Six months after surgery only the faintest signs of incoordination and awkwardness were present in the hand, and gross muscular strength seemed normal. He had returned to work full time and considered himself completely recovered. The mild arterial hypertension continued unchanged, and he is being maintained on anticoagulant medication today, one year after his "stroke."

This exemplifies the dramatic results occasionally possible with operative treatment of a patient with an arteriosclerotic cerebrovascular "accident." The clinical picture was indistinguishable from those in patients with hemiplegia due to quite different lesions. Treatment was dependent upon establishment of the anatomic lesion precipitating his stroke—in this instance cervical segmental arteriosclerotic disease—together with prompt therapy directed at the cause. Cerebral arteriography established

a diagnosis in this case in simple, unequivocal fashion.

DISCUSSION

It is hard to account for the medical inertia that has effectively blocked widespread use of cerebral angiography for accurate diagnosis of the common types of cerebral dysfunction. It is true that in the initial stages of development of angiography, injection of various radiopaque media into cerebral arteries occasionally led to serious complications and even death.[18] However, since those early days, new liquid media and revised methods have increased immeasurably the safety of the patient undergoing cerebral angiography.[19] Thousands of cerebral arteriograms have been safely performed in the past few years,[4] often in desperately ill patients.[15] Investigators reporting large series of cases from various clinics have stressed the extremely low morbidity and absent mortality accompanying these studies. Certain clinics even use the technic as an out-patient procedure, handling these neurologic cases in much the same way as they process medical patients for any routine radiographic study.[20] There have been no reports of serious complications with any of these mass methods of employing the newer dyes. *There is, therefore, no evidence that the risk of cerebral angiography today is at all commensurate with the frequently grave risk to the patient of the condition for which the test is used.* Under these circumstances it would seem to be mandatory that every effort be made to utilize cerebral angiography in each case of clinical "stroke" to establish a precise, objectively substantiated diagnosis—and then to base therapy upon the solid factual data so obtained.

Every neurologist of experience is acutely aware of how hard it is to make an exact anatomic diagnosis of factors productive of a "stroke" when he has to rely solely upon clinical findings. Even in the most "ordinary" hemiplegia, the clinical signs and symptoms are usually a manifestation of sudden gross failure of function of a large part of a cerebral hemisphere with no hint as to precise pathology responsible for that failure. The exact precipitating factors underlying more sophisticated neurologic syndromes may be even more complex and difficult of interpretation using purely clinical data. So long as hemiplegias produced by such widely differing causes as unilateral chronic subdural hematoma, arteriosclerotic occlusion of a cervical carotid artery, or thrombosis of a middle cerebral artery may not always be readily distinguished by their presenting neurologic signs and symptoms, then other more accurate diagnostic means are essential.

In many cases, the temporal profile of neurologic illness may be extremely helpful. In most patients with "stroke," however, diagnosis on this basis alone (even when taking into consideration all clinical information available) remains a statistical estimate and not a substantiated diagnosis of pathology actually present in that patient. For example, careful clinical examination may readily distinguish an ischemic brain infarct from a cerebral hemorrhage in a patient with "stroke"—or perhaps differentiate with ease the site of dysfunction as being in brain stem or occurring in a cerebral hemisphere. But the precise anatomic cause of any of these relatively sudden interruptions of normal brain activity usually remains obscure unless clarified by appropriate diagnostic technics.

TECHNIC

Cerebral arteriography is not unduly complicated. If the patient has a hemiplegia or hemiparesis, initial dye injection is made in the opposite cervical carotid artery. If brain stem dysfunction is suspected, brachial vertebral angiography is performed. Occasionally both of these methods are used in the same patient, and in some patients it may be further required that the other common carotid artery is injected.

18. Kaplan, A. D. and Walker, A. E.: Complications of Cerebral Arteriography. Neurology, 4:643 (1954).

19. Kenan, P. D., Tindall, G. T., Margolis, G. and Wood, R. S.: Prevention of Experimental Contrast Medium Injury to the Nervous System. J. Neurosurg., 15:92 (January 1958).

20. Dimant, S.: Cerebral Angiography in a Neurosurgical Service. Brit. M. J., 2:10 (1956).

Adults are brought to the x-ray department under sedation. The studies are conducted under local anesthesia. Sterile precautions are observed. An 18-gauge Cournand® needle is inserted into the selected carotid artery. Sensitivity testing is carried out. Ten cubic centimeters of a 50 per cent solution of sodium diatrizoate† are injected for each film series. Ordinarily a lateral and occipital series are sufficient to establish the diagnosis, but other projections may be of value. Films are inspected to determine their diagnostic quality before the needle is withdrawn. Somewhat different amounts and concentrations of dye are used for brachial-vertebral studies.

A clear, well-defined silhouette of the cerebral vascular tree filled with contrast material has been obtained in a personal series of over 100 "strokes" of all kinds investigated by these technics. *There has been no morbidity and no mortality in these patients associated with cerebral angiography.* These studies have served to accentuate the frequent large discrepancies between clinical and anatomic diagnoses of patients with "stroke." They have also established unequivocally that a variety of lesions have the capacity to produce clinically similar states of cerebral neurologic dysfunction. Finally, they indicate that future progress in the management of cerebrovascular disease depends greatly upon prompt utilization of all available modern investigative technics for patients manifesting such disease, for it is largely through such studies that treatment can be anchored to the solid foundation of an accurate diagnosis.

SUMMARY AND CONCLUSIONS

1. In most patients developing hemiplegia due to a "cerebrovascular accident," the precise anatomic nature of the responsible lesion cannot be determined by clinical neurologic examination.

2. Cerebral angiography is a safe and reliable technic to aid accurate diagnosis of both the common and uncommon types of brain dysfunction.

3. Due largely to knowledge gained through cerebral angiography, concepts of mechanisms involved in precipitating an "ordinary stroke" manifested by hemiplegia are undergoing marked evolution.

4. Advances in treatment of "stroke" victims have proceeded side by side with precise delineation of causal lesions. Segmental cervical carotid disease (frequently amenable to surgical repair) has emerged as an important cause of cerebral infarction. The mortality rates produced by intracranial hemorrhage are capable of dramatic reduction by vigorous management. And, for certain patients proved to have sustained brain infarction due to diseased cerebral vessels, anticoagulant therapy will produce sustained remission of neurologic signs and symptoms.

†We use the Winthrop brand tradenamed Hypaque®.

20 Madison Avenue

Lion's Share

Lion's share of the medical care dollar now goes to hospitals. They get 28 cents of each dollar John Q. Public spends for health; physicians get 27 cents. He spent more dollars, $3,182 million, on personal care (toilet articles, barber and beauty shops) than on either hospital or physician services. John Q. also elected to spend 5.1 per cent of his total personal consumption expenditures on recreation as compared with 4.4 per cent on all medical care items.

—Journal of the Medical Association of Georgia, Nov., 1956.

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Urologic Aspects of Hypertension*

We are accustomed to thinking of hypertension as essentially a problem in cardiovascular management. However, the disease has a urologic aspect, too, as Dr. Murphy here points out.

The pathogenesis of hypertensive cardiovascular disease is still not clearly understood, but it appears certain that the kidneys and the adrenal glands are intimately involved. There appears to be little doubt, for example, that certain types of unilateral renal disease may cause or aggravate the hypertensive state. Tumors of the adrenal medulla may produce constant or intermittent elevation of blood pressure. Removal of both adrenal glands in patients with "essential hypertension" markedly affects the course of this disease.[1] The purpose of this discussion is to outline a logical approach to hypertension from the urologic standpoint, to emphasize the value of some diagnostic procedures as well as the risks involved in performing them and to demonstrate in the light of recent experience how the urologist may contribute effectively to the management of this common and serious disease.

*Read May 20, 1958 before the Section on Urology of The Medical Society of New Jersey at their Annual Meeting in Atlantic City. This work is from the Division of Urology, Hospital of the University of Pennsylvania and the Harrison Department of Surgical Research, Schools of Medicine, University of Pennsylvania, Philadelphia.

1. Blakemore, W. S., *et al.*: Treatment of Severe Arterial Hypertension. Surgery, 43:102 (January 1958).

2. Smith, H. W.: Unilateral Nephrectomy in Hypertensive Disease. J. Urol., 76:685 (December 1956).

3. Perera, C. A. and Haelig, A. W.: Hypertension Associated with Unilateral Renal Disease. Tran. Am. Physicians, 65:134 (1952).

SELECTION OF PATIENTS

It is apparent from a review of past experience [2] that only a limited number of patients with hypertension may be benefited by urologic intervention. The size of this group seems to increase each year, probably because of increasing interest, advances in diagnostic technic, and improvement in methods of reparative surgery. Certain types of patients are more likely than others to have urologic disease as a cause of, or contributing factor to, their hypertension. Table 1 summarizes the chief characteristics by which these patients may be selected. Perera [3] and others have emphasized the significance of acute asymptomatic and rapidly progressive hypertension especially in the younger age groups. Essential hypertension is extremely uncommon in children and when discovered merits careful and complete investigation. Acceleration of the disease process in a known hypertensive of the middle age group or onset of hypertension after the age of 55 are absolute indications for complete urologic study. Intermittent hy-

TABLE 1.

SELECTION OF PATIENTS

1. Young hypertensive (birth to 30 years).
2. Acute, symptomatic, rapidly progressive disease.
3. Unilateral abnormality on urogram.
4. Intermittent hypertension and/or "crises."

pertension or sustained hypertension accompanied by episodes of apprehension, palpitation, and diaphoresis suggest the possibility of pheochromocytoma and demand the clinical and laboratory studies which will confirm or refute this diagnosis.

All patients with hypertension should have a urinalysis, determination of the blood urea nitrogen or non-protein nitrogen, serum creatinine, phenolsulfonphthalein excretion and an intravenous urogram. The latter should be done even if the blood urea nitrogen is elevated for with the new and more concentrated iodine compounds now available for intravenous urography, visualization of the collecting system may be obtained by roentgenograms made six to twelve hours after injection of the medium. Any difference in the pyelographic appearance, renal size or function as demonstrated by intravenous urography warrants further investigation. Disturbances of renal function on one side may not be detectable on the intravenous urogram and if the patient fits into one of the categories outlined above it may be worthwhile to perform other studies to compare the function and circulatory status of the kidneys. At this point the urologist and the internist must confer and select patients deserving further investigation.

DIAGNOSTIC STUDIES

Determination of individual renal function is a valuable study which may be easily accomplished. Large size (7 or 8 F) ureteral catheters are passed to each renal pelvis while the patient is in a state of hydration sufficient to produce 1 to 3 cubic centimeters per minute of urine flow from each kidney. Care must be taken to avoid leakage around the catheters and gross discrepancies in urine flow. Corrections must be made for gross blood in the urine specimens. Function may be evaluated by the half hour creatinine clearance test, phenolsulfonphthalein excretion, sodium excretion,[4] and comparative urine volumes. The differential creatinine clearance test[5] is done by collecting all of the urine produced by each kidney for a half hour period. Clearances are calculated from determination of creatinine in these specimens and in a sample of serum obtained at the time of the urine collection. Diminution of creatinine clearance or PSP excretion from one kidney, supported by decreased sodium excretion of 20 per cent or more on the same side is good evidence of unilateral renal disease.

Retrograde pyelograms may be made at the termination of the excretion and clearance study. Caution should be exerted in doing bilateral retrograde pyelograms in patients with borderline renal reserve. Temporary interference with renal function because of overdistention of the pelvis or pyelo-renal back flow might produce serious consequences in such patients. Unilateral pyelograms made at two or three day intervals will avoid this danger. An obviously contracted kidney with a classical picture of diminution of parenchymal bulk, distortion of the calices and displacement toward mid-line due to perivascular fibrosis is a picture not easily mistaken for anything else. A normal pyelogram may be found in the presence of serious functional renal disease, as, for example, in the case of vascular lesions. A vascular lesion may be proved only by renal angiography. This may be accomplished by trans-lumbar aortography, or by so-called selective angiography performed through percutaneous puncture of the femoral artery. A flexible catheter is introduced into the aorta through a percutaneous puncture of the femoral artery under local anesthesia. The tip of the catheter is directed with fluoroscopic guidance into the renal artery. Injection of a relatively small amount of radio opaque medium permits visualization of the entire arterial system of the kidney.

Another approach which has some promise for determining the renal blood flow and function of individual kidneys involves the intravenous injection of radioactive iodopyracet† and the estimation of renal blood flow and tu-

†Iodopyracet is commercially available under the Winthrop-Stearns tradename of Diodrast®.

4. Howard, J. E., *et al.*: Hypertension Resulting from Unilateral Renal Vascular Disease. Bull. Johns Hopkins Hospital, 94:51 (1954).

5. Nesbitt, T.: Determination of Function of the Individual Kidney. J. Urol., 71:407 (April 1954).

bular function from records obtained by scintillation counters placed over the renal areas.[6] This method is still in the investigative stage but it is hoped that it will provide a screening test which will obviate the need for more complex and traumatic tests in some patients.

Accurate delineation of the size and shape of the renal and suprarenal structures is sometimes of great value in the study of hypertension. Retroperitoneal insufflation of gases provides an excellent method for accomplishing this end. Carbon dioxide has been found to be the safest medium for this study because of its greater solubility in serum. This greatly decreases the likelihood of gas embolism.[7]

Needle biopsy of the kidney has been advocated as an aid in diagnosis. This has real value from the investigative standpoint, but it is not recommended as a routine diagnostic procedure because of the vascularity of the organ and the seeming inadequacy of the sample obtained. Connor[8] and the group at Johns Hopkins Hospital suggest that there is a characteristic histologic pattern of ischemic tubular atrophy in kidneys contributing to hypertension. If this is substantiated and if the safety of needle biopsy is proved by further experience it may well provide a valuable diagnostic aid.

Hypertension due to adrenal disease includes the elevation in blood pressure noted in Cushing's syndrome because of adrenal hyperplasia and that due to adrenal pheochromocytoma. The diagnosis of adrenal hyperplasia is made on the basis of physical findings, steroid excretion studies, and the demonstration of increased adrenal size on intravenous urography and retroperitoneal pneumography. The latter examination is especially valuable in delineating adrenal glands in the case of suspected pheochromocytoma. Indications to perform this study (in addition to the classical syndrome of intermittent palpitation, anxiety, diaphoresis and headache) are intermittent or sustained hypertension in a patient with increased levels of catechol amines in the serum or urine. A relatively simple and accurate method for determining catechol amines quantitatively is accomplished at the University Hospital by the rabbit aorta method.[9] A segment of rabbit aorta is suspended in a controlled temperature chamber to which is added carbon dioxide and oxygen and a quantity of serum or urine from the patient. Contraction of the aorta is measured on the kymograph and compared to that produced by a known concentration of norepinephrine and serum or urine from a normal control.

A recent experience with this tumor illustrates the diagnostic and therapeutic approach. A middle aged woman had complained for several months of intermittent episodes of headache, palpitation and diaphoresis. She was found to be markedly hypertensive during one of these episodes. Her catechol amine excretion was markedly elevated. No sign of the tumor could be seen on intravenous urography but perirenal carbon dioxide insufflation delineated a large rounded lesion above the kidney. The tumor was resected without event and she has been asymptomatic and normotensive since operation.

UNILATERAL RENAL DISEASE

When the abnormality causing unilateral renal disease has been determined, treatment is directed at correction of the defect with emphasis upon the conservation of functioning renal tissue. Relief of obstruction to urinary flow is the simplest type of therapy if applicable. Surgical correction of ureteropelvic junction obstructions, or those caused by aberrant vessels, calculi or strictures is an obvious approach. Certainly, such lesions may cause hypertension. A recent experience emphasizes this point. A 15-year old boy was struck in the right flank while playing foot-

6. Winter C.: Unilateral Renal Disease and Hypertension. J. Urol., 78:107 (August 1957).

7. Blakemore, W. S., Murphy, J. J., Pendergrass, H. P. and Greening, R.: Carbon Dioxide as Contrast Medium in Roentgenography. J.A.M.A., 167:310 (May 17, 1958).

8. Connor, T. B., *et al.*: Bull. Johns Hopkins Hosp., 101:241 (July 1957).

9. Janetta, P., Nell, H. and Blakemore, W. S.: Evaluation of Bioassay and Fluorometric Methods for Measuring Catacholamines in Urine. *To be published.*

ball and complained thereafter of persistent discomfort in this area. Examination three weeks prior to the trauma had revealed him to be normotensive and in apparently good health. He was hospitalized for investigation of the flank pain and found to have a blood pressure of 180/110 with eye ground changes suggesting acute hypertension. Intravenous urogram demonstrated delayed function of the right kidney with dilatation of the collecting system. Ureteropyelography confirmed this impression and revealed a severe obstruction of the uretero-pelvic junction apparently due to extrinsic pressure. Exploration of right renal fossa confirmed this finding, revealing an aberrant artery and vein compressing an angulated uretero-pelvic junction. The ureter was freed from the vessel and ureteropyeloplasty accomplished to permit normal drainage. The blood pressure returned to normal on the third postoperative day and has remained at 130/70 since that time. A recent intravenous urogram demonstrates adequate drainage of the kidney and return to a nearly normal pyelogram.

Removal of a contracted pyelonephritic kidney is another simple approach which is effective in 25 to 50 per cent of patients with hypertension in whom this disease is found. Success or failure of the procedure depends upon the amount of damage existing in the opposite kidney and this appears to be directly related to the duration of the hypertension. Many patients will have a decrease in their blood pressure after surgery and the rest which follows the operative procedure. In evaluating the results of surgery for unilateral renal disease in hypertension long term follow-up is essential and only if the blood pressure is within normal limits two years after operation can one say that the surgery produced the desired effect.

Correction of a vascular anomaly or disease depends upon the individual lesion. Obstruction of a renal artery by an arteriosclerotic plaque appears to be the most common lesion of this type while angulation or external compression of the vessel, narrowing of the lumen due to fibrous proliferation of the intima, idiopathic strictures, aneurysm and congenital coarctation make up the majority of the remainder. The following patients illustrate some of these lesions.

1. A 12-year old boy had hypertension of known duration of at least three years. His blood pressure ranged from 220/110 to 240/120. A mild cerebral vascular accident occasioned the admission which will be described. An intravenous urogram appeared perfectly normal. An attempt at translumbar aortography was unsuccessful and visualization of the renal arterial system was finally accomplished by the rapid injection of 50 cubic centimeters of radio opaque material into an arm vein with rapid exposure of multiple films as for angiocardiography. Some of these films demonstrate narrowing of the left renal artery very close to the aorta (Figure 1).



Figure 1. Angiogram demonstrating coarctation of left renal artery.

Exploration confirmed this finding but because of the proximity of the narrowed area to the aortic wall nephrectomy had to be performed rather than arterial grafting. Within nine months the child was normotensive and has remained so for the past three years. His urine continued to show albumin and red and white blood cells for the nine month period while the tension was still elevated, but these findings gradually returned to normal with the blood pressure.

2. Another anomaly or perhaps some form of localized arteritis was discovered in a young woman with hypertension of recent onset and rap-

idly progressive disease characterized by severe headaches. Intravenous urography failed to show the left kidney until the 20 minute film when the pyelogram appeared to be perfectly normal. Differential renal function studies were carried out (Table 2) demonstrating markedly diminished excretion of creatinine and sodium on the left side as compared to the right. Selective renal angiography demonstrated an irregular tortuous narrowing at the central portion of the renal artery on the left side (Figure 2). Exploration of this area demonstrated the narrowed area which was resected and continuity of the artery was restored by end-to-end anastomosis by Dr. W. S. Blakemore. The patient has remained normotensive since the procedure. A recent urogram demonstrates prompt function bilaterally and apparently normal pyelograms. Differential renal function studies carried out a few weeks ago demonstrate equal function on both sides.

TABLE 2.

RENAL FUNCTION: PRE-OPERATIVE

	Right	Left
Urine volume, cubic centimeters per half hour	200	75
Creatinine clearance, milliliters per minute	57	27
Sodium excretion, milliequivalents per liter	6	2



Figure 2. Selective angiogram revealing narrowing of central portion of renal artery.

SUMMARY

Advances in the clinical recognition of certain hypertensive states, improved diagnostic methods and new technics of reparative surgery have opened new vistas for management of this troublesome disease. Intelligent application of this knowledge by the internist and urologic surgeon should result in a very satisfactory decrease in morbidity and mortality due to hypertension.

3600 Spruce Street

Survival Tip

Rats given large doses of radiation have poor muscle responses and tire rapidly with little exertion. Exercised animals die sooner than rats that are kept quiet. Dr. Thomas J. Haley of the University of California at Los Angeles therefore believes that persons who survive total body radiation by an atomic or hydrogen bomb blast should find some protection from hot debris and remain quiet for several days before trying to walk out of a bombed area.—*Modern Medicine*, July 1, 1958.

Historical Article • • •

Samuel Berg, M.D.
Newark

The Essex County Pathologic and Anatomic Society: The First Fifty Years*

They say that the first fifty years are the hardest. The unique Essex County Pathologic and Anatomic Society has seen a half century of change; but it still remains a pioneer in often-forgotten components of basic medical scholarship

The doctor today has a rich choice of graduate courses, institutes, seminars, tape recordings, books, conventions and even television teaching. At the turn of the century, however, the physician who wanted to keep up to date, had to work hard at it. It wasn't available in predigested form as it now is. One of the standard ways of keeping fresh your knowledge of anatomy and pathology was to join an anatomic and pathologic society. Here you would do dissections and autopsies and by constant seeing-for-yourself (the original meaning of the word *autopsy*) you would keep sharp the cutting edge of your medical knowledge. In most states it was easy enough to develop such a society. But not in New Jersey. The anti-dissection laws made it impossible to form such an organization. To permit the studious doctor to leap over this hurdle, the New Jersey Legislature passed Chapter 247 of the laws of 1907.

This law provided that: "any three or more physicians licensed to practice medicine under the laws of New Jersey, who shall desire to associate themselves together for the purpose of pathological and anatomical study and the advancement of medical and surgical science may make, record and file a certificate in writing." The remainder of the law pertains to administrative matters, particularly in reference to obtaining bodies for dissection.

The leading spirit behind this legislation was Dr. Theodore Teimer, a 35-year old physician who had received his medical degree in 1896 from the University of Vienna. Dr. Teimer came to Newark in 1897 and was destined to serve the people of this state for many decades. Vienna at that time was the world center of medicine. Dr. Teimer sorely missed the scientific atmosphere of that university city, and for several years after his arrival here, he discussed the possibilities of instituting educational opportunities in Newark. Several of his colleagues were imbued with the same desire. Most encouraging were Drs. Julius Levy and David Kraker. Their efforts resulted in the enactment of Chapter 247 of the Laws of 1907. Dr. Teimer invited a group to his home on the first floor of an apartment house at 667 High Street, Newark, on December 27, 1907. Here there was discussion of the scope and purposes of the proposed society and of the articles to be incorporated in a constitution. The founding members were Doctors Theodore Teimer, Julius Levy, Louis L. Davidson, Albert M. Baciewicz, Nathaniel Price, David Kraker and Herbert Long. Dr. Teimer was elected president and Dr. Levy was the first secretary. The papers of incorporation were filed on January 2, 1908, and

*Delivered November 9, 1957 on the occasion of the 50th Anniversary of the founding of the Society.

a bond in the amount of one thousand dollars was supplied by Dr. Levy's father.

The next meeting, on January 3, 1908, was held in Dr. Levy's home at 298 Bank Street, Newark. Of the remaining six meetings that year, one was at Pfeil's Funeral Parlor† at 127 Court Street, one at Goldsticker's Funeral Parlor† at the corner of High Street and Springfield Avenue in Newark. The other sessions were at Dr. Teimer's home. In July 1908, Dr. James Lowrey was elected to membership, and in November, Doctors Edward Ill, Harry Epstein, Francis Haussling and Wells P. Eagleton: as distinguished a quartet of surgeons as the state had produced. Two dissections were done this first year. The minutes of the November 1908 meeting state that Dr. Epstein proposed that the Society "cooperate with the newly appointed pathologist at the Newark City Hospital, Dr. Harrison S. Martland, in our efforts to obtain material for dissection and pathological specimens for study." Little did Dr. Epstein realize, in making this suggestion, that the fortunes of the Society were being tied to a star. This was the most momentous event in the affairs of the Society.

Some Blue Law proponents attempted to repeal the law permitting Anatomical Societies to dissect unclaimed bodies in March 1908 and, with the backing of some municipal officials, again in January 1909; both times without success. They tried to interfere with or nullify the purposes of such a society by introducing legal technicalities relating to the definition of "unclaimed body." Indeed, the Newark Board of Health went so far as to appoint a Committee which asserted jurisdiction over unclaimed bodies. This attempt to sabotage the Society was again frustrated.

The Society already had a distinguished roll call: Theodore Teimer and Julius Levy; Louis Davidson and David Kraker; Wells P. Eagleton and Francis Haussling; Harry Epstein and Edward Ill. To this, there were added in 1909 a dozen new names which gave added strength to the Society. The 1909 additions included Victor Parsonnet and Christopher Beling; Max Danzis and Adrian Strasser; Elbert Sherman and William Miningham; John Gray and Charles Kip; E. Zeh Hawkes, Albert Harden, Theodore Corwin, Hugh Cook, Charles Ill, George Rogers, John Read, William Gauch, Harold Tarbell, H. J. Wallhauser, Eugene Wolf, George Emory, and, at the end of the year, a man who was to add a special luster, Harrison S. Martland.

The influx of applications from men of this caliber indicated that the Essex County Pathologic and Anatomic Society had supplied something needed in the development of our profession. In a broad sense, what was supplied was an aura of scholarship, a sense of intellectual adventure. In a more practical way, the Society offered the opportunity to dissect anatomic material, to improve surgical skills, to teach pathology, and to offer a forum for the presentation of specimens.

The first scientific program was offered on October 21, 1909 at Achtel-Stetter's restaurant on Broad Street. There were presentations by Doctors Haussling, Harden, Sutton, Strasser, Martland and Wallhauser. In November 1909, Doctors Harden, Epstein, Gauch, Wallhauser and Martland were on the program. Foreshadowing his later versatility—and productivity, Dr. Martland presented 6 specimens. In December 1909, again at Achtel-Stetter's, Dr. Homer Coffin, Professor of Pathology at New York Post-Graduate College, was invited to give an illustrated talk. This was the first of many eminent physicians invited to give lectures under the auspices of the Society. Today we complain if a medical society holds 9 or 10 meetings a year, and it is hard to get more than a corporal's guard for even six sessions a year. But in 1909, the Essex County Anatomic and Pathologic Society held 15 meetings—and there was never any trouble getting a quorum. In 1910, the organization held 17 sessions! Six were scientific presentations at Achtel-Stetter's, the others were dissection or study programs.

By now, membership had reached 68. Included in the new galaxy were names like Clarence O'Crowley, Charles Teeter, Edward Sprague and others. Also new was a rented

†A funeral parlor may seem an odd place for a medical meeting. However, these doctors were dissecting bodies. And what better place for a corpse? Editor (son of one of the founders).

room as a permanent headquarters. It was located behind Hanagan's Tavern at the corner of New Street and Halsey Street.*

One of the attractions of the scientific sessions was the post-meeting dinner. Nothing so delicate as a "collation" or a "snack." Achtel-Stetter's provided some of the best German cuisine in an area where Germanic culture was long dominant. And in its special way, Hanagan's was also noted for its good food. The doctors were hearty eaters who needed no Duncan Hines to tell them where the food was good.

DURING 1911, membership reached 87. Eighteen meetings were held. In September 1911, the Society moved to the quarters of the newly formed Academy of Medicine of Northern New Jersey on the top floor of the Wiss Building at 671 Broad Street, Newark. A museum was started with 90 specimens presented by 61 members. A course in hematology was given by Dr. Martland. Dr. Teimer gave up the presidency, after 4 years, to Dr. Haussling.

The next half dozen years moved in high gear. Executive meetings were held at the homes of members of the Board of Governors and scientific sessions at the Academy of Medicine quarters in the Wiss Building. After October 1916 these meetings were at the then-new Board of Health building on Plane and William Streets. Members presented interesting cases. Dr. Gray displayed material from St. Michael's Hospital, and Dr. Martland, with Dr. Arturo Casilli assisting, presented material from Newark City Hospital. New members were elected almost every month. By 1918, there were 180 members. The First World War erupted in 1914. This had its impact on the previously peaceful way of life in the United States. Few meetings were held in 1918, and none in 1919. Dr. Martland was in service overseas with the Bellevue Unit.

From 1920 on, the tempo picked up. The proportion of case reports by members decreased, that of autopsy material increased, especially from City Hospital. The latter were presented for the most part by Dr. Martland's assistants, in turn Doctors Asher Yaguda, Joseph Echikson, Samuel Berg, and Murray Shulman. Discussions, however, were by the maestro: Harrison S. Martland. By the mid-twenties, membership had reached 230.

A trail-blazing session was held on March 25, 1926. Dr. Von Sochocky spoke on the use of radio-active material in the treatment of cancer. And then, in a discussion of the paper, Dr. Martland presented epoch-making histioradiographs produced by the action of radio-active mesothorium deposited in the bones of girls who painted the luminous dials on watches. It was an eerie prelude to the atomic age. Twenty years before Hiroshima, Harrison Martland was able to give the members of our Society a preview of history.‡ Only a few months ago, the Federal Government issued flyers asking physicians to try to find these women—those who survived—for a follow-up study of early victims of the age of radiation. Martland was the pioneer in this and our Society one of his earliest sounding boards.

DURING the 1930s, the Society developed the famous Tuesday evening clinico-pathological conferences by Dr. Martland at the City Hospital. These were well attended, especially so after construction of a large amphitheater in 1940, where patients could be wheeled in, autopsy material shown on a screen by means of an epidiascope and lantern slides projected in black and white or in color. For years, these sessions were followed by a dash to Sidney's on Prince Street for the best in delicatessen and camaradie.

Dr. Martland became internationally renowned for his original and basic research in the field of biologic effects of ingested radioactive substances. But his local fame rested on the incomparable manner in which he conducted these instructive conferences. Tuesday

*A tavern did not then have its current implication as a meeting place. George Washington said farewell to his officers at Fraunces Tavern, and The Medical Society of New Jersey was founded by a group of doctors meeting at a tavern in New Brunswick. The tavern was, until recently, the public place—the pub—*par excellence*.—Editor.

‡And Major Samuel Berg was to direct the laboratory investigations on the atom-bombed victims in Nagasaki in October-November, 1945, and direct the first survey on the harmful effects of radioactive fall-out in nearby Nishiyama in November, 1945.—Editor.

was post-graduate night. It was also Essex County Pathologic and Anatomic Society night. The conferences were sponsored by our Society. The cost of the programs mailed to every physician and of the posters sent to every hospital in the County was borne by the Society. The very epidiascope in the amphitheatre was donated by the Society and a special refrigerator to hold autopsy material in good condition was purchased by the Society. If the Society sponsored nothing else, this alone would justify its existence.

But the Society did sponsor something else. It established, in 1935, the Harrison S. Martland Annual Lecture to honor, in life, this most distiguished member. Speakers to date have been Doctors Whipple, Ewing, Gettler, Libman, Boyd, Goldblatt, Rhodes, Leowi, Ash, Waksman, Lawrence, Warren, Duff, Selye, Helpern, Dalldorf, Klemperer, Stewart, Fishberg and Farber. The mere recital of this galaxy is enough to indicate the titles of their lectures. In delivering the results of their epochal research personally before New Jersey physicians, these celebrities of medical science represented, not only themselves, but also the medical profession in general, in paying homage to Dr. Martland.

In 1952, the Society established the Harrison S. Martland Annual Award, with a first prize of $250 for the best paper relating to pathology or anatomy written by any resident or intern in New Jersey. This has stimulated some excellent research among our neophyte physicians.

In 1957, a series of slide seminars was instituted. It remains to be seen if physicians in this age are sufficiently interested in cytopathology to make this venture successful.

One sometimes wonders if, with all our wonderful advances in medicine, the level of scholarship is as high now as it then was. To keep his knowledge of otologic anatomy up-to-date, Wells P. Eagleton did not rely on books, universities, slides, or experience. He dissected the mastoid region and did it again and again. So Harry Epstein dissected the thyroid area, William Krone the sinuses, Edward Ill the biliary tract, Clarence O'Crowley the prostate region. In a way that might seem monotonous to modern students, these surgeons kept their hands skilled and their visual imagery of the area clear. This constituted a powerful *raison d'etre* for the Society.

Today it is said the universities discourage this kind of self education. They sell post-graduate courses and frown on the do-it-yourself technic of an earlier generation. Some of the medical schools, indeed, take all unclaimed bodies, leaving none for Anatomic Societies.

The Society has overcome problems in the past. It remains for the younger doctors to meet and mount such hurdles in the future. We have reason for pride in the half century of our Society. As we pass the torch to younger hands, we remind them of their heritage. We are sure they will be worthy of it.

156 Roseville Avenue

Open Air Sewage

A human being breathes in 10,000 quarts of air in every 24 hours. In an industrial environment, each quart of air also contains a chemical cocktail of potentially poisonous or cancer-causing substances. Toxic materials that have been found in suspended matter include lead, mercury, cadmium, arsenic, beryllium, sulfurous materials, nitrates.—*MD*, January, 1958.

Announcements • • •

Dr. Williams to Academy of Arts

Dr. William Carlos Williams, a member of The Medical Society of New Jersey, was elected last month to the American Academy of Arts and Letters. Described by the *Times* as "one of America's most exclusive cultural institutions," membership in this Academy is limited to fifty—usually considered the 50 top men and women of American letters. Dr. Williams is a distinguished American poet and a frequent laureate of prizes and awards.

What State Hospital for Your Patient?

New Jersey now has four state hospitals. Doctors who have occasion to commit patients are sometimes uncertain as to which state hospital receives from which county. We are informed by the Commissioner of Institutions and Agencies that the following allocation has been made.

Marlboro State Hospital receives from the counties of Ocean, Middlesex, Monmouth and Union.

Ancora State Hospital receives from the counties of Atlantic, Camden, Cape May, Cumberland, Gloucester and Salem.

Trenton State Hospital receives from the counties of Hudson, Hunterdon, Mercer, Somerset, Warren, and from the cities of Newark, Belleville and Nutley.

Greystone Park receives from the counties of Bergen, Morris, Passaic, Sussex and also from all of Essex County except Newark, Belleville and Nutley.

Patients living in Burlington County go to *Trenton* unless they live in Bass River, Washington, Woodland or Shamong. From these four townships patients go to *Ancora*. From the rest of Burlington County, patients go to *Trenton*.

If you do not file your JOURNALS, it is suggested that you make a copy of this for desk display.

Awards for Manuscripts on Obstetrics and Gynecology

The International College of Surgeons announces competition for the best manuscripts on any phase of obstetrics and gynecology. The first award will be $500 and the second $300.

The contest is limited to (1) interns, residents, or graduate students in obstetrics and gynecology, or (2) to those engaged in the practice or teaching of the specialty. Contestants must hold a medical degree. Fellows of the International College of Surgeons are not eligible.

Manuscripts of not more than 5,000 words must be submitted before June 1, 1959, to Dr. Harvey A. Gollin, 55 East Washington Street, Chicago 2. For information on contest rules, write to Dr. Gollin.

Grants for Ophthalmologic Research

The National Society for the Prevention of Blindness invites requests for research grants in 1959. Funds are available for projects that may contribute to an understanding of eye function and pathology, that may improve methods of diagnosis, treatment or prevention of blinding eye disease. Grants will be made for requests received prior to May 1, 1959. Inquiries are addressed to Research Committee, National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Marginalia of Medicine • • •

This department is at your service for (1) asking questions, (2) answering them, (3) contributing little odds and ends of knowledge and experience that are not solemn enough for a full article, but interesting enough to be shared with your brethren. Send the contribution to Marginalia, the JOURNAL, *P.O. Box 904, Trenton 5, New Jersey.*

14

Regarding Marginalium 9, Dr. Daniel O' Regan of Jersey City, writes:

Club-hand is a congenital deformity (or a variety of deformities) characterized by radial deviation of the wrist and hand. It is usually due to dysplasia involving the distal third of the radius. There may be absence of the thumb and index fingers, plus their metacarpals and corresponding carpals. The entire radius plus the radial rays of wrist and hand may be absent, although part of the radius is usually present. Due to relative overgrowth of the distal ulna, the wrist and hand are forced into radial deviation, which may reach 90 degrees or more. Bowing of the ulna, due to soft tissue contracture, may also result. The limb is shortened, and function of the hand is poor. Muscles may be hypoplastic or absent, also.

Treatment consists of: (1), keeping the hand in the functional position, which requires some ulnar deviation, until bone has matured enough so that a fusion can be done. This also prevents and/or overcomes soft tissue contractures; (2), some kind of stabilizing procedure to keep the wrist and hand in the functional position. Several procedures are used. In one, a bone graft is added to the distal ulna to form a Y-shape at the distal end. The two ends of the Y are then fused to the wrist. In another procedure, the wrist is displaced laterally, so that the distal end of the ulna is in the center of the carpus, and fusion is done. The important thing is to get the hand in the functional position and keep it there. Plastic procedures are done on the hand as needed, such as pollicization of the index finger in the absence of the thumb.

I hope that this information will be useful. It should demonstrate that we read THE JOURNAL, if nothing else.

Next question!

15

Marginalium 3 asked whether there "was any fairly simple formula for deciding when a peptic ulcer should be subject to surgery." Dr. A. I. Friedman of Hackensack replies as follows:

Unfortunately, this cannot be answered 'simply.' The indications for surgery depend on whether one is dealing with a gastric or duodenal ulcer, age of the patient, a history of past or present complications, frequency of recurrence, duration of the ulcer, roentgen diagnosis and a host of other factors. The chief consideration in a gastric ulcer in my opinion is whether it heals completely, as evidenced by roentgen examination, at the end of 4 weeks of intensive medical hospital care. If it does not, surgery is indicated. When the roentgen evidence for a benign lesion is unequivocal the patient may be treated for 6 weeks before advising surgery. Intractibility of symptoms in duodenal ulcer despite intensive medical care often suggests penetration into adjacent tissues or organs. This, too, is usually an indication for surgery. Obstruction, and hemorrhage after age 50 are indications for surgery. Before 50, until a second episode of bleeding, surgery may be delayed. Uncontrolled massive hemorrhage obviously requires emergency surgery, particularly after age 50.

Complications of ulcer after age 50 are associated with a significantly higher morbidity and mortality.

County Societies Reports • • •

Atlantic

The regular monthly meeting of the *Medical Society of Atlantic County* was held November 14, 1958, at the Children's Seashore House. Dr. S. Eugene Dalton, the President, was in the chair.

A scientific program was opened by an introduction of the guest speaker by Dr. David Allman, the Past President of the American Medical Association, and member of our society. The guest speaker was William A. Sodeman, M.D., the Dean of the Jefferson Medical College. The subject for the evening was "The Collagen Diseases."

The subject was discussed by Drs. Walker, Ackerman, Bressler and Harley.

The business meeting was then conducted by Dr. Dalton.

The minutes of the previous meeting were approved as published in the *Bulletin* for November. The minutes of the Executive Committee were read and approved.

Dr. Samuel Southard, reporting for the Public Health Committee, made the following resolution:

> Whereas the efficiency of the poliomyelitis vaccine in the prevention of paralytic poliomyelitis has been well established, and whereas we realize that a large segment of this population has not received immunization, we, therefore, re-affirm our previous recommendation that the entire population, especially those under forty years of age, receive poliomyelitis vaccine injections at the proper intervals.

There was some discussion as to the limitation to those under forty. Some of the members believe that the injections should be given to the older groups also. Dr. Allman emphasized the importance of this campaign as part of the American Medical Association campaign. The resolution was adopted.

Dr. Harley, reporting for the Public Relations Committee, emphasized the program for the coming year. The following points were made:

1. The physician is the equivalent of good or bad public relations, and each member should make an effort to further good public relations.

2. The Emergency Medical Service, as outlined by the Chairman of that committee, Dr. Donald Davidson, at the previous meeting, is important and all members should cooperate.

3. The radio program, founded, organized, and managed by Dr. Ruby, called "Your Doctor Speaks" should be continued. The Public Relations Committee suggested receiving suggestions from the listeners as to the type of program they would prefer. It was also suggested that Dr. Ruby be relieved at times from the constant job of the programs.

4. The Public Relations Committee is to ask certain doctors to write a feature article for the *Atlantic City Press* each week. Any member offering such an article should call Dr. Steel.

Dr. Molitch recommended that Dr. Carl Kramer be raised from associate membership to full membership. This was approved. Dr. Molitch stated that he had written to other counties and that the fees authorized by the Welfare Department in this county were the equivalent of the other counties. No county is getting higher fees and one reported that they were getting lower fees. All fees were paid directly to the patient because of a national ruling.

Dr. Harris stated that five local doctors, all in good standing, and Mr. Jackson, a pharmacist, had formed a corporation which was called the "Ethical Pharmacy Corporation." Legal counsel on the local level and the A.M.A. on its level, stated that this was ethical. Dr. Molitch reported that he had received a complaint and, therefore, was making an official investigation which is routine for the Censorship Committee. Dr. Allman stated that at the national level there was nothing unethical in this corporation, and if the local doctors were forming this for the benefit of the patients, they should be congratulated. As long as the corporation works on an ethical basis, there should be no complaints.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society*, held December 9, 1958, at Bergen Pines Hospital, was called to order by George Heller, M.D., President.

The President noted the presence of Past President, Leo J. Fitzpatrick. After expressing appreciation for the fine administration, ably led by Dr. Fitzpatrick during the preceding year, Dr. Heller thanked him in the name of the Society for his outstanding leadership. He then presented Dr. Fitzpatrick with a Past President's Pin. This action was soundly applauded by the members present.

Dr. Campbell, Secretary, read the following names of the two Regular members elected at the last meeting and presented their membership certificates: Herbert E. Keller and Thomas F. Lynch.

A new Associate member was asked to rise: Gerald R. Frolow.

The following, who had been approved by the Executive Committee, were elected: To Regular from Associate—J. Robert Botta, Elias Lika and Pauline P. Territo; To Regular by Transfer—Edward R. Duty; To Associate—John G. Bell, Jr. and

Alfred Del Vecchio; To Emeritus—William Carlos Williams.

The meeting was temporarily suspended at this point by the President, who asked Dr. Tor Richter, Chairman of the Scientific Program Committee, to present the speaker of the evening. Dr. Richter introduced Mr. Earl Ubell, Science Editor of the New York Herald Tribune. Mr. Ubell outlined the procedure of getting newsworthy copy printed in a daily paper and emphasized that once an article is written, the writer has no control over headline, space, or even cutting his work. He stated that doctors do not know what the public knows about medicine and that it is almost impossible to do a good job of public education through a mass medium. Therefore, said Mr. Ubell, it is important that the doctor realize that in his office he has the best opportunity for public medical education because the individual patient is in a more receptive frame of mind than when he is well and needs no medical care. The speaker discussed the problem of patients who arrive in the doctor's office with a newspaper or magazine clipping about a new drug and want to know why the doctor will not prescribe it. Mr. Ubell suggested that the doctor keep himself informed about these new medical discoveries to be able to discuss them intelligently with his patients. It is up to the doctors to educate the public in personal preventive medicine. Mass media cannot do it.

Mr. Caldwell of the *Bergen Evening Record* also spoke. He did not agree that public education cannot be effected by mass media. It is his belief that newspapers, magazines, TV and radio, can provide a general basic interest. Because of this it is then easier for the doctors to instill a recognition of the values of an individual preventive program. Mr. Caldwell added that just because doctors have felt for years that their public relations are poor, does not mean that this is so. If this was so, no physician could remain "in business." He pointed out that the professional individual usually enjoys a fine reputation with his own patients or clients. Mr. Caldwell emphasized that it is not out of keeping for doctors to discuss with local press representatives patients they have treated in a newsworthy episode and urged that members of this Society do so.

After a spirited question and answer period, the President expressed the appreciation of those present for the speakers' unusually able presentation of a subject long misunderstood by the medical profession.

Dr. Felix Vann called attention to the critical shortage of acceptable nursing homes for the chronically ill and aged. He then read a resolution and moved its adoption. After being seconded by Dr. Verdon, the resolution was passed and the Secretary instructed to forward it to The Medical Society of New Jersey for study and report at its next annual meeting.

CHARLES P. CAMPBELL, M.D.

Reporter

Essex

The December meeting was held jointly with the Academy of Medicine of New Jersey and the Essex County Pathological and Anatomical Society at the Essex House in Newark, on December 17, 1958. The Harrison S. Martland Memorial Lecture was given by Vincent du Vigneaud, Ph.D., Professor of Bio-Chemistry, Cornell University Medical College and concerned "The Hormones of the Posterior Pituitary Body."

WILLIAM A. ANDERSON, M.D.

Reporter

Gloucester

The regular meeting of this Society was held at the Woodbury Country Club on December 18, 1958.

Charles H. deT. Shivers, M.D., Emeritus Professor of Clinical Urology at the Graduate School of the University of Pennsylvania, spoke on "Urological Problems Confronting the General Practitioner." He emphasized the importance of early diagnosis, and treatment, particularly for renal or ureteral calculi. He believes congenital anomalies are more common than are usually diagnosed in children.

The following were approved for membership in this Society: William D. Kehler, M.D. and I. William Glemker, M.D., both from Woodbury.

The Gloucester County Guidance Center for Mental Health reports the need for more help with the increasing patient load. Dr. George Rogers will be present at the March meeting for discussion with this Society.

Dr. Chester Samuelson volunteered to attend a meeting of the New Jersey Nutritional Council on January 11, 1959 as our representative.

Drs. A. Guy Campo and Louis Collins were elected to attend a meeting of County Society representatives concerning the State Society's Constitution.

Drs. Collins, Black and Rozanski were given a vote of thanks for their services in the typhoid prevention program in Glassboro. Dr. Samuelson suggested letters be written and sent to Drs. Bergsma, Palmer and others making clear the facts of this whole program. Also, it was the opinion of members present that a more active participation by physicians in public health problems be promoted with local Boards of Health.

Dr. Collins made a motion, favored by members, that Dr. A. Guy Campo be nominated as our choice for the second vice-presidency of The Medical Society of New Jersey.

Adjournment followed a collation served by the Country Club Staff.

DOROTHY M. ROGERS, M.D.

Reporter

Mercer

The Society's annual banquet, held at the Trenton Country Club, Wednesday evening, December 10, 1958, was attended by 205 regular members, 6 associates, and 12 guests.

Dr. Raymond A. McCormack served as toastmaster.

The guest speaker was Jacques M. May, M.D., Director, Department of Medical Geography, American Geographical Society, who spoke on "The Geography of Human Disease."

A past-president's plaque was presented to Dr. A. James Fessler, Sr., in recognition of services rendered the Society during his administration (1957-1958).

The guest speaker at our January 14th meeting was Dr. Herbert R. Hawthorne, Professor of Surgery, Graduate School of Medicine, and Chairman, Department of Surgery, Graduate Hospital, University of Pennsylvania, whose subject was "Hiatus Hernia, Peptic Esophagitis, and the Ulcer Diathesis."

The results of a postal card poll of our members on compulsory inclusion in O.A.S.I. (Social Security) were announced. The response, as of this date, indicates an overwhelming majority in favor of such inclusion.

Physicians elected to Associate membership were Drs. Mary Ann B. Bartusis, Alex J. Krawczun, Mark H. Lund and John C. Wood.

LAWRENCE I. BONIN, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held on December 17, 1958, at 9:00 p.m. at the Roosevelt Hospital, Metuchen, with Dr. George J. Kohut, the president, presiding.

Drs. Albert Barsi, Colonia, Herbert Bloom, Perth Amboy and Dorothy Sved, Highland Park, were elected to a two-year period of Associate membership. Dr. Jasper Van Avery of New Brunswick was elected to Regular membership by transfer from the McHenry County Medical Society, Merendo, Ill.

Emeritus membership was unanimously approved for Dr. William H. McCormick, Perth Amboy.

A motion was approved to examine the Constitution and By-Laws proposed by the American Medical Association for each county society. This aims at uniformity throughout the U. S. A.

Mr. P. Witcoff, of the Narcotics Squad, Newark Police, spoke on the relationship between the doctor and the narcotics bureau. The talk was followed by many questions from the members and enlightening answers by the speaker.

The Public Relations and Public Health Committees made the following recommendations: (1) that the Middlesex County Medical Society urge poliomyelitis immunization; (2) that it be given in the physician's office; (3) that the Middlesex County Medical Society urge its physicians to participate in mass immunizations whenever feasible; and (4) that the Boards of Education require such immunization before admitting children to school. The members unanimously approved these recommendations.

It was reported that 130 of our members voted "yes" for compulsory inclusion in Social Security as polled by postal card; 55 members were already included in Social Security; there were 52 who voted "no." A motion to make this known to the Bergen County Medical Society and The Medical Society of New Jersey was unanimously voted.

DONALD T. AKEY, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, December 9, 1958 at 9:00 p.m. at the Medical Society Building. The President, Dr. Theodore K. Graham, presided.

The following physicians were elected to Active membership: Drs. Richard Fadil of Clifton, Anthony R. Gennaro of Paterson, David M. Niceberg of Passaic, Don Tunis Van Dam of Oakland; elected to Associate membership were Drs. David Eilenberg and Jaroslaw Rozankowski, both of Paterson.

A resolution on the death of Dr. John F. Cremens was read, and it was adopted as read.

An inquiry from the Bergen County Medical Society, in connection with compulsory inclusion in O.A.S.I. (Social Security), was brought before the members. Dr. Graham asked the members to express their thoughts on the suggestion of conducting a poll in order to determine their feelings toward such inclusion.

A motion was made and carried that cards be sent to the members of this Society asking whether or not they favor inclusion in Social Security.

The meeting was turned over to Dr. Irving Chrisman who called upon Dr. Murray Nussbaum to introduce the guest speaker, Mario Stefanini, M.D., Assistant Professor of Medicine and Pharmacology, Tufts College Medical School, Boston. Dr. Stefanini's subject was "Fibrinolytic Mechanism." A question period followed.

After the scientific session, refreshments were served.

DAVID B. LEVINE, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held at the Du Pont Penns Grove Country Club on December 19, 1958 with Dr. Charles E. Gilpatrick presiding.

Dr. Harry W. Fullerton reported on opinions developed regarding the advisability of administering a fourth dose of Salk Polio Vaccine. Following the recommendation of Dr. Louis Coriell of Camden Municipal Hospital it was felt that a fourth inoculation was advisable. This dose is to be given a year after the third one.

Dr. Isadore Lipkin, President of the Salem County Heart Association, announced that Dr. William A. Jeffers of University of Pennsylvania Hospital, will be the guest speaker at a Society meeting to be held at Elmer Hospital in March, 1959. Dr. Jeffers has been obtained through the efforts of the Salem County Heart Association and his subject will be "Hypertension and its Treatment."

The members endorsed the action of the American Medical Association and the U. S. Public Health Service in recommending a drive to popularize the use of seat belts in automobiles.

Dr. Lee C. Hummel of Salem was appointed to the post of director of the Civil Defense Disaster program for the Society in Salem County.

Following a business meeting the speaker for the evening was Mr. Johnston P. Caveny, a special agent for the Northwestern Mutual Life Insurance Company, who was introduced by Dr. George Nitshe. Mr. Caveny's subject was "Life Insurance and Income Tax." He clarified the various terms annuities, endowments, premiums, *et cetera*, and outlined several ways of securing the most beneficial personal insurance programs coupled with lowered income tax payments. He also felt that the physicians as a group would soon be included in those who are covered by the Social Security program.

A lively question and answer session followed the discussion illustrating the stimulation of thought by the speaker.

G. F. REICHWEIN, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Water and Electrolyte Metabolism in Relation to Age and Sex. Ciba Foundation Colloquia on Aging. Pp. 327. Boston, 1958. Little, Brown & Company. ($8.50)

In the practice of medicine and surgery whether it be pediatrics or geriatrics, the physician is constantly dealing with electrolyte metabolism. To acquaint the medical profession more accurately with these unknowns, the Ciba Foundation here assembles the essays presented by a group of scientists who have been exploring cell metabolism, electrolyte and fluid balance, especially in relation to age and sex. This volume is a reference source which belongs in the library of every medical student and physician. At the end of each printed essay there is an interesting series of questions and answers which serve as an instructive addition to the paper. These queries shed light upon the clinical reasoning and practical application of the accumulated data.

All of the papers presented are interesting and timely. Some of the essays, such as the following, deserve emphasis because of their clarity and their application in the field of geriatrics. (1) Hypernatraemia (water deficiency) and hyponatraemia or salt deficiency or excessive dilution of extracellular fluid with water; (2) Hormones and electrolyte metabolism with a discussion of adrenal hyperplasia, adolescence, pregnancy and a very interesting sidelight on the role of potassium in prolonged labor and its effects on uterine contraction; (3) The role of the kidney in electrolyte and water regulation of the aged. The author (N. W. Shock) discusses in a simple conversational manner the various phases of the ultimate "Death of the Nephron"; (4) Renal function in respiratory failure with the decline of the functional capacity of the lung and kidneys with advancing age caused by an increase in respiratory dead space and progressive loss of nephrons; (5) Water electrolytes in congestive failure, and (6) Development of acid base control.

To more fully appreciate ageing as explained by the concept of cell metabolism, fluid and electrolyte balance, this book of essays is highly recommended.

HARRY HALPRIN, M.D.

Modern Clinical Psychiatry. A. P. Noyes, M.D. and Lawrence C. Kolb, M.D. Philadelphia 1958. Saunders. Pp. 694. Edition 5. ($8.00)

For a quarter of a century, *Noyes* has been an acceptable psychiatric text in American medical schools and hospitals. The fact that its readers have made five editions necessary is sufficient accolade. This edition is graced by the service of Columbia University's distinguished professor of psychiatry as co-author. In less than 700 pages the text covers psychopathology, diagnosis, treatment, forensic problems, examination technics and the historical development of psychiatry. It is a solid book, steering between the extremes and gives the reader the facts in a simple, no-nonsense, non-crusading fashion.

HENRY A. DAVIDSON, M.D.

Experimental Pharmacodynamics. By T. Koppanyi and A. G. Karczmar. Ed. 2. Pp. 258. Minneapolis, 1958., Burgess Publishing Co. ($5.50)

In general, the reviewer is favorably impressed by the organization and content of this manual on experimental pharmacology. The experiments are well conceived and the authors' inclusion of a discussion on the general pharmacology and clinical relevance of each subject is a refreshing change from the traditional "laboratory manual" approach. With this format the manual succeeds in serving as an "introduction to pharmacology." It is not, however, a substitute for a good textbook on the subject. A number of significant errors appear in the discussions; also several misleading inferences based upon what appears to be incomplete coverage of the literature (particularly in the section on psychotherapeutics). The authors ascribe the clinical effects of chlorpromazine, reserpine and analgesics to actions on specific areas of the brain for which there is no substantive proof. The term "tranquilizer" suffers when psychomotor stimulants such as Meratran® and Ritalin® are classified as tranquilizers. The authors also confuse the subject of drug antagonism in their efforts to differentiate physiologic and competitive antagonism, and incorrectly refer to nalorphine-morphine antagonism as physiologic. A surprisingly large number of typographical misspellings are present in the text, *e.g.*, zerost*i*mia, dipher*h*ydramine, meninococci, and others. Also, except for two chapters, the authors neglect to capitalize proprietary names of drugs to distinguish them from generic and official names, as is customary. Oversights such as these leave an impression of carelessness in preparation which detracts from the text. Taken as a whole, however, the authors have provided a useful manual of experimental pharmacology with a number of very desirable features.

SAMUEL IRWIN, PH.D.

An Introduction to Experimental Medicine. By Claude Bernard. Translated by Henry Copeley Green. New York 1958, Dover Publication. Paper. Pp. 226. ($1.50)

Claude Bernard wrote this book in 1865. It is now available in a sturdily bound, inexpensive English translation. The text falls into three divisions, one on reasoning, one on experimentation and one on applications of such methods to medicine. The philosophy is sound and appropriate today, and the book itself is a part of our medical heritage. Bernard discusses the value of error and mistaken hypotheses in getting to the truth. The discussion of vivisection would be valid today. The treatment of the morals and ethics of human experimentation can stimulate discussion in any twentieth century conference room. Statistical analysis was poorly developed in the mid-19th century, and Bernard's skepticism about it was justified at that time. Two readable forewords—one by I. Bernard Cohen and one by L. J. Henderson add to the value of the book.

ULYSSES FRANK, M.D.

Urology in General Practice. By Frank Coleman Hamm, M.D. and Sidney R. Weinberg, M.D. Philadelphia, 1958. J. B. Lippincott Co. Pp. 293. Paper. ($6.00)

The aim of this book is to introduce the medical student and resident to urology and to provide a ready reference to those in other branches of medicine and surgery. The authors have considered the problems of urology against the larger spectrum of general medicine. There is greater emphasis placed on the group of typical degenerative diseases than is found in the usual urologic symposium designed as an elementary text. Since the older age group is increasing and will continue to do so, the general practitioner will have more demands made upon his knowledge and skill in the diagnosis and treatment of degenerative diseases.

A good working knowledge of urologic problems is essential for those doing general medicine. The principles involved are fundamentally no different from those in other divisions of surgery. But urology differs in two important respects: The first is the use of the cystoscope, a remarkable instrument that facilitates accurate diagnosis and allows specialized operative procedures. And of equal importance, are technics that allow the kidneys to function while surgery of the urinary tract is being done.

The authors have written an excellent review of urologic problems and procedures, admirably suited for teaching to medical students and residents. It is a source of much diagnostic information for the general practitioner, also. A major fault, however, is that treatment is inadequately outlined in

many cases. The reason, perhaps, is that in most of these cases a well trained urologist is necessary for the fulfillment of the therapy.

MORTIMER REICH, M.D.

The Preservation of Youth. By Moses ben Maimon, better known as Maimonides. New York 1958. The Philosophical Library. Pp. 92. ($2.75)

This book was written in AD 1198. It comes to us in a translation by Tadbir As Sihha. It covers twelfth century advice on diet, sleep and exercise. Maimonides never heard of cholesterol, but he advises against eating animal fats. The therapy recommended by Maimonides includes cupping, purges, scarifications, enemas, and "light" drugs. Also included is a reliable aphrodisiac. It requires the use of Sodom's apple, fumaterra, polypody and the myrobalan of Kabul. The book is an interesting and permanent part of our medical heritage.

ABRAHAM LEFF, M.D.

Love, Skill and Mystery. By Theodor Bovet, M.D. Garden City, N. Y. 1958. Doubleday and Company. Pp. 188. ($3.50)

A Swiss physician, Dr. Bovet, here offers the American public a handbook on marriage. There is some discussion on the mechanics of coitus (the doctor prefers a dimly lighted room to a dark one), of budgeting, of contraception, and of courtship. ("A young man who spills a glass of claret over his girl's dress will learn more about her character then than in ten nights' courting.") He believes that schizophrenia, diabetes and anemia are inherited, that divorce is never justified, and that his rhythm formula "can be regarded as infallible." He also thinks that buying furniture on the installment plan is a threat to marriage ("it is better" he says, "to sleep on the bare floor" than to do that). There is consistent emphasis on the spiritual side of marriage. He believes that the man is the head of the partnership and that marriages work out better when the husband is smarter. The husband, he says, "should be coxswain of the marital boat"—a statement which probably sounds less interesting in *Schweitzer Deutsch*.

VICTOR HUBERMAN, M.D.

The Neurologic Basis of Behavior. Edited by G. E. Wolstenholme, M. B. and Cecilia O'Connor, B.S. Boston 1958. Little Brown. Pp. 400. ($9.00)

In July 1957 a group of distinguished scientists held a symposium in London. It commemorated the centennial of the birth of Sir Charles Sherrington—and it was the kind of commemoration he would have liked: significant, scholarly, yet lively. Now, under the auspices of the Ciba Foundation, the symposium has been brought together between hard covers.

It is a truism to say that psychiatry (and, by extension, psychosomatics) is at the cross-roads. One arm of the road leads to an explanation of behavior abnormalities in terms of personal experiences, group experiences, social interraction and the like. The other arm of the road clings to the organic-physiologic concept of mind as the secretion of the brain. It looks for physiologic changes in the brain, as an organ, to account for behavior changes in the organism. The contributors to this seminar belong to the latter school. Nineteen papers are included, each concentrating on some facet of neurophysiology: brain enzymes, rhinencephalon, physiologic response to stress, diencephalic stimulation, and lesions of the dorsomedial thalamic nucleus of the cat. Appended to every paper is the give and take of intelligent discussion transcribed verbatim. On the whole, the book is a solid and scholarly contribution to medicine in general and psychiatry in particular. And for all one knows now, it may be that the key to fit the door of the mind will be fashioned in the physiological laboratory rather than on the analyst's couch. If so, this book will prove to be a roadmap to the future.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

February, 1959 • Vol. XXXII—No. 2

TUBERCULOSIS, A DISEASE OF OLD AGE

The highest mortality from tuberculosis has now shifted to the older age groups. This has created new problems in therapy and control which may be complicated by social and economic conditions. Tuberculosis hospitals are needed to care for aged persons.

Since the beginning of this century and especially since the most recent advances in the battle against tuberculosis through effective chemotherapy, the age distribution of the disease has changed radically wherever a concerted attack on tuberculosis has been possible. The first great change was accomplished through effective sanitation of the milk supply, which resulted in control of bovine tuberculous infection in the United States; the secondary manifestations of bovine infections, particularly tuberculous osteomyelitis, have since become comparatively rare.

FAMILIAL EXPOSURE TO TB IMPORTANT

This achievement in combination with the enlightened concept that the exposure to the human bacillus in home life is the main source of clinical pulmonary tuberculosis resulted in a decline of the mortality among children to very low values even before the era of chemotherapy. During the past decade it has almost reached the zero point.

The steady decline of the mortality curve for the total population during the past 50 years shows some of the factors which are at work in the tuberculosis problem. In the United States the picture is greatly influenced by the prevalence of the exudative and progressive forms of pulmonary tuberculosis among the nonwhite and immigrant elements of the population, chiefly the Negroes, the Puerto Ricans, and the refugees from war-tortured countries, and to some extent also by the American Indian. Undoubtedly, the published statistics convey an overoptimistic impression if it is interpreted in terms of "cured" or "healed" tuberculosis. We know that the lower mortality is not the mere result of the decrease in the number of new active cases. Therefore, it must be assumed that, especially during the past 10 years of chemotherapy, the swiftness of the decline of the mortality is due to the increasing chronicity of the disease, which has shifted its weight into an older age group of the population. This change has become one of the most burning problems in tuberculosis care.

DEATH RATES SHOW SHIFT TO OLDER AGES

Tuberculosis used to be the greatest killer of mankind during the prime of life but today the peak of the mortality during the second and third decades of life has flattened to comparatively insignificant values. The second peak, during the seventh decade of life, now has emerged as the highest elevation.

Recently published reports of the World Health Organization show that the shift of the highest mortality to the senile age is universal; they also indicate the persistence of a high mortality among children in some countries.

In the past, the cirrhotic, the fibroid, and the fibrocaseous forms of pulmonary tuberculosis have been a rather uniform finding in elderly patients. Most always they had been tuberculous for many years, although the old disease was frequently associated with new bronchogenic exacerbations. In recent years, it has been a surprising and somewhat puzzling experience to find many fresh exudative involvements in patients where the absence of tuberculosis had been established when they were already in the old age group. The

ROBERT G. BLOCH, M.D., *American Medical Association Archives of Internal Medicine, June,* 1958.

likeliest explanation is that in previous generations, when roentgenologic examination was less commonly applied, the disease was not looked for in older persons.

Nowadays we find in the tuberculosis wards many patients who were hospitalized for some nontuberculous disease associated with tuberculosis. The true situation now is that the old tuberculous patient dies with rather than of tuberculosis. Often he has been sent to the tuberculosis wards for isolation rather than because of the symptoms of tuberculosis and the need for its treatment.

NEED FOR ISOLATION

The question of the infectiousness of tuberculosis in some ways has become more complicated through modern chemotherapy rather than simplified. The patients belonging to the group with sputum abundantly positive on direct microscopic examination and culture cannot be permitted to return home to live with children and young adults even under the most favorable living conditions. Those in the group in which the production of bacilli is diminished to occasional and scant positive results on culture are considered by many authors as practically non-infectious. However, the continuous contact in intimate home life has long proved itself as the essential cause of clinical tuberculosis. Therefore, extreme caution is indicated lest we send home not only parents to infect their children, but also grandparents to infect their grandchildren. This thought should apply even to the group of patients with negative sputum findings of seeming reliability. The fact that resected lesions from such patients yielded tubercle bacilli on either microscopic or cultural examination, or both, in well over one-third of all cases, offers much food for thought and caution.

The social, economic, and emotional problems of old age tuberculosis even overshadow the medical difficulties. The senile patient is lonely and wretched; often he has neither family nor friends; if he is widowed, his children, themselves beset by poverty, may not be able and at times are not willing to add to their burden by ministering to him. The old patient is frightened and helpless, and his reliance on social and welfare agencies is complete.

HOME CARE NOT COMPLETE ANSWER

Since chemotherapy has come to the fore, the idea of home care for the tuberculous has received widespread attention. Unquestionably the period of hospitalization can now be shortened, but home therapy without an initial stay in a hospital or sanatorium cannot be recommended. It is bound to fail in many aspects of diagnosis and therapy and deprives the patient of the indispensable education in the meaning and in the demands of his disease in the specifically created atmosphere of the tuberculosis hospital. When the time for discharge and home care approaches, a thorough investigation should be made of the home situation. Supervised rest and quiet, cleanliness, and comfort are still the mainstay in the treatment of tuberculosis. As yet, nobody has offered proof that the old methods can be replaced simply by the free provision of antibiotics by the community, even assuming that the drugs are taken as they were prescribed.

The closing of tuberculosis hospitals and sanatoria in reliance on modern chemotherapy is premature. They should serve as the desperately needed homes for homeless aged tuberculous patients, where they can enjoy a secure, dignified, and happy existence. Institutional care for tuberculosis will develop more and more to a crying need as the disease increasingly becomes a geriatric problem.

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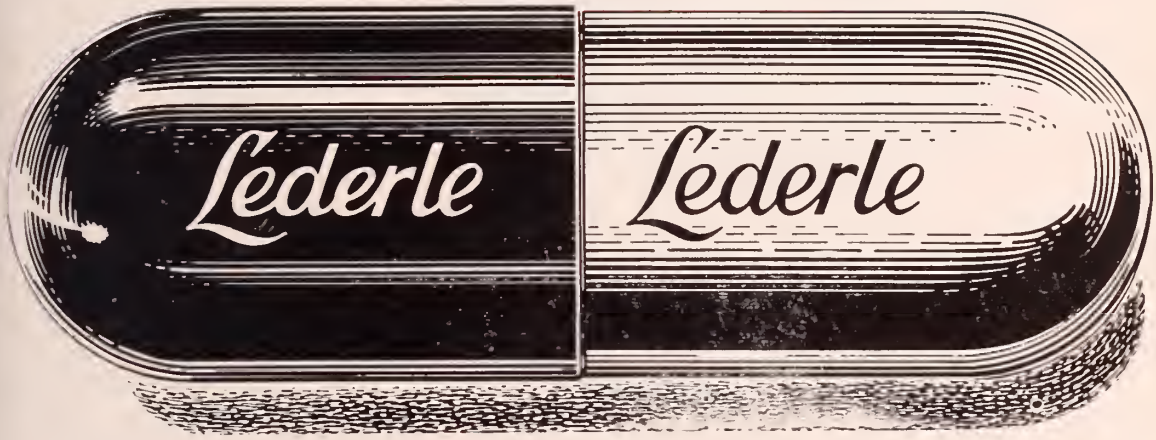
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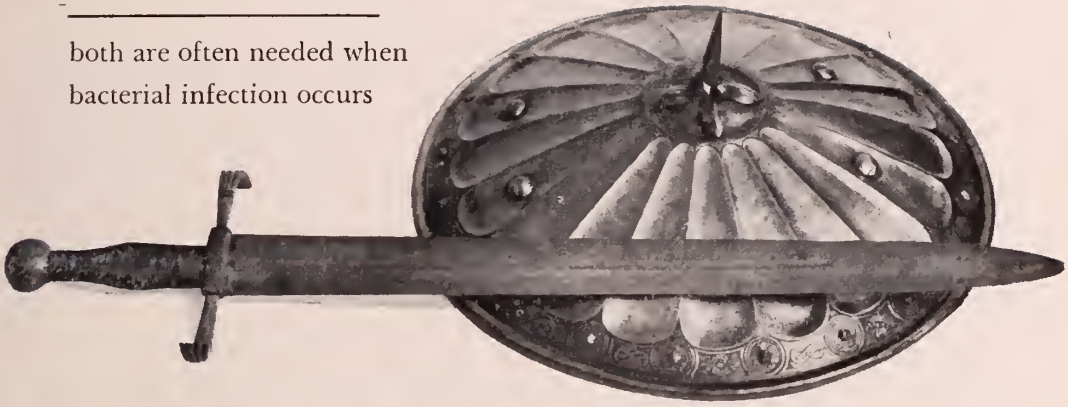
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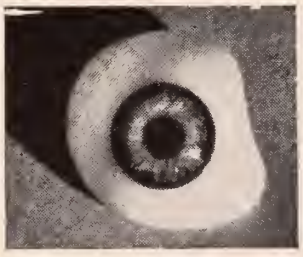
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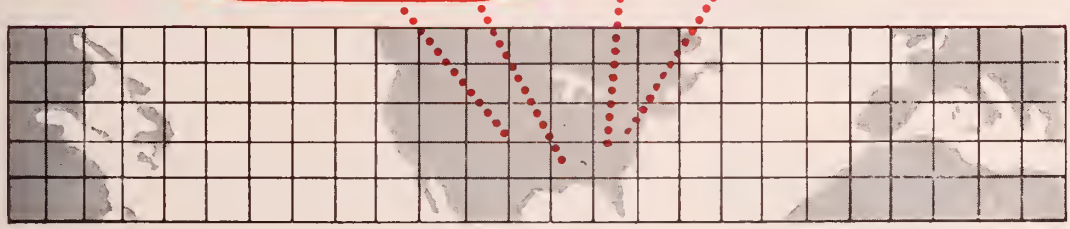
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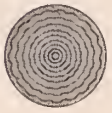
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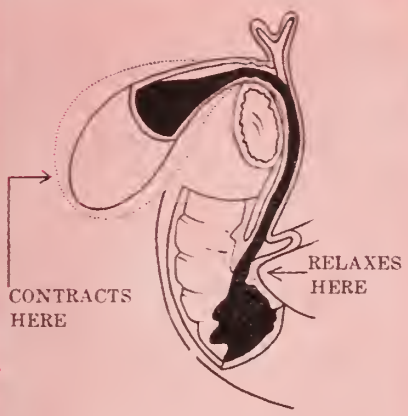
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1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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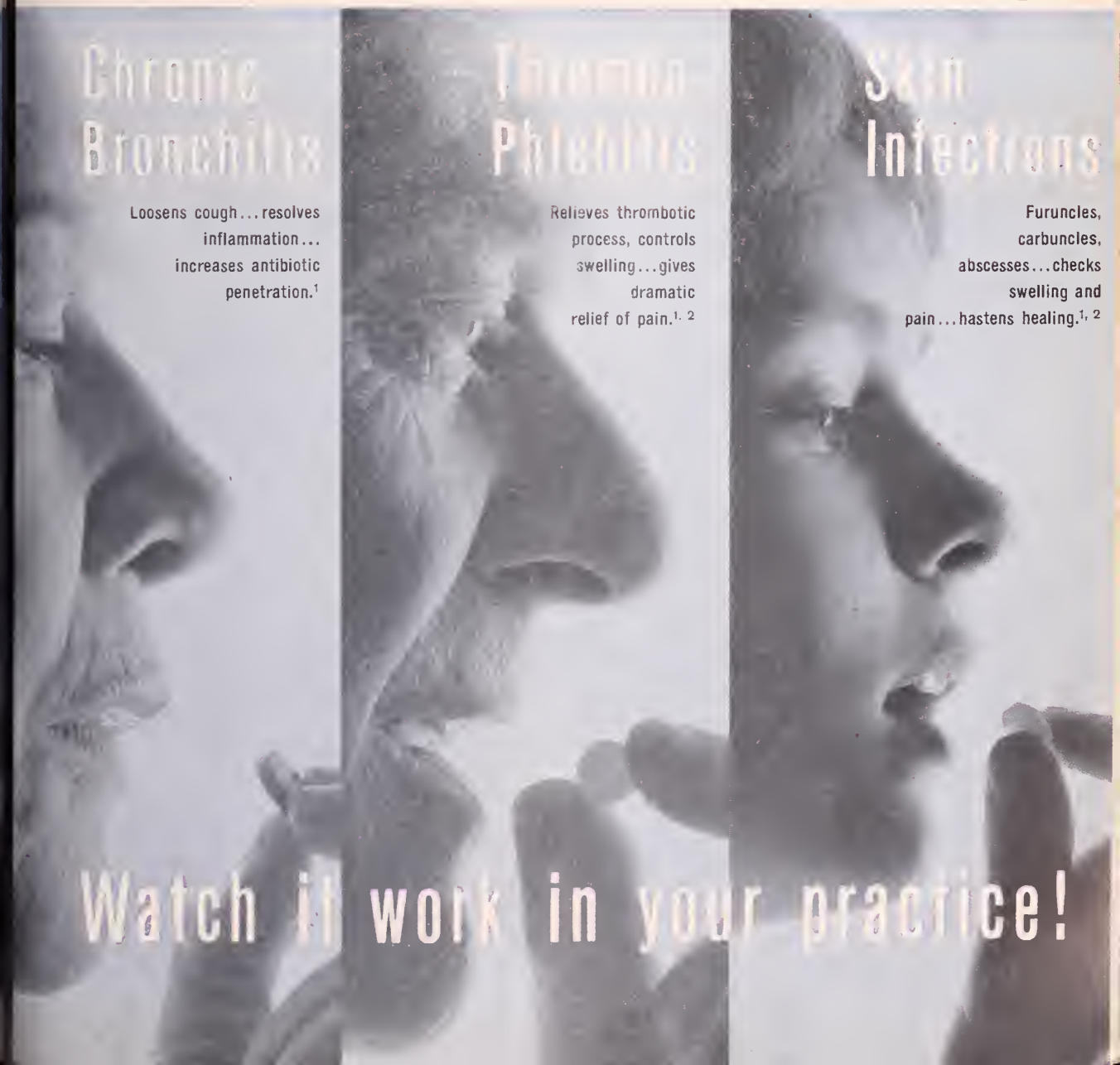
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In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

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Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases, Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
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4. J. A. M. A., 167:1584, July 26, 1958.
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6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
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9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

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1. Levy, S.: J.A.M.A. 153:1260, 1953.

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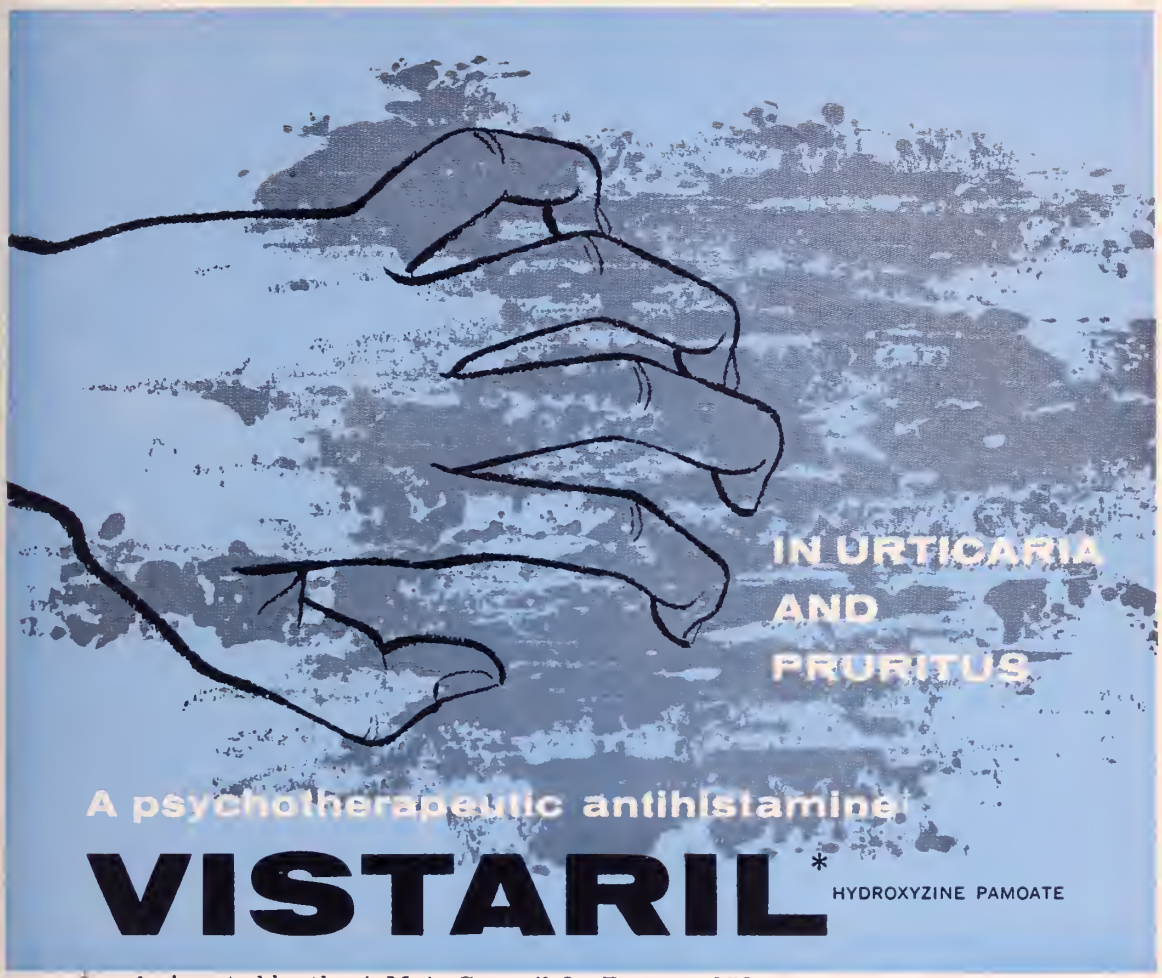
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References: 1. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 2. Eisenberg, B. C., Clinical Medicine *5*:897-904 (July) 1958. 3. Robinson, H. M., et al.: J.A.M.A. *161*:604-606 (June 16) 1958. 4. Robinson, H. H., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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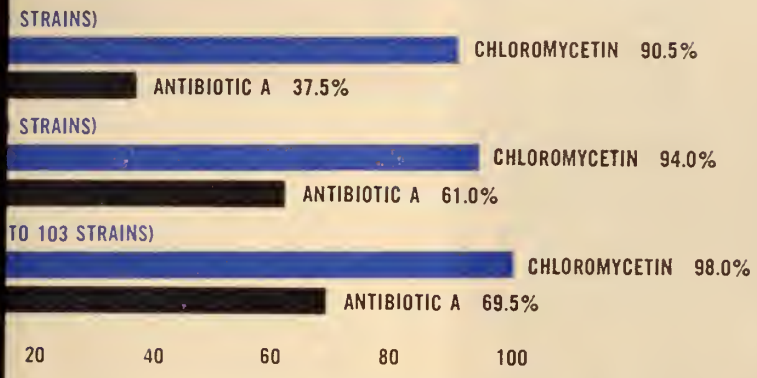
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REFERENCES: (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 30:175, 1958. (2) Roy, T. E., *et al.*: *Canad* 77:844, 1957. (3) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (4) Royer, A., in Welch Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (5) Blair & Carr, M.: *J.A.M.A.* 166:1192, 1958. (6) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* 106:1, 1958. (7) Fekety, *et al.*: *Am. J. Pub. Health* 48:298, 1958. (8) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (9) Kessler, & Scott, R. B.: *J. Dis. Child.* 96:294, 1958. (10) Shaffer, T. E.: *J. Michigan M. Soc.* 57:851, 1958.

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THE JOURNAL

OF

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CONTENTS—Pages 95 to 152

	Page
EDITORIALS—	
Liability and Progress	95
Competition in the Drug Industry	96
ORIGINAL ARTICLES—	
Survival After Three Potentially Fatal Surgical Complications—Harold M. Fischer, M.D., East Orange, N. J. and Ralph Rosamilia, M.D., Newark, N. J.	97
Rheumatic Fever Prevention—Thomas M. Kain, Jr., M.D., Camden, N. J.	99
Psychogenic Factors in Infertility—Edward N. Comando, M.D., Newark, N. J.	104
Recent Experiences with Urinary Diversion—G. T. Whittle, M.D., Asbury Park, N. J.	108
Unusual Biliary Tract Disease—William L. Palazzo, M.D., Teaneck, N. J.	110
Electrophoretic Mobility of Hemoglobins—Thomas K. Rathmell, M.D., Thomas V. Egan, B.S., M.T. (ASCP) and Jorge Mora, M.D., Trenton, N. J.	113
Common Gait Disturbances in Children—Bertram M. Kummel, M.D., Morristown, N. J.	117
Treatment of Hyperthyroidism with Radioactive Iodine—Louis J. Levinson, M.D., Newark, N. J.	120
ORIGINAL ARTICLES—	
Treatment of Arthritis with Amphetamine and Analgesics—John A. Strazza, Jr., M.D., Bloomfield, N. J.	124
Postoperative Gastro-Intestinal Roentgenography—Herbert Greenfield, M.D., Newark, N. J.	128
STATE ACTIVITIES—	
Diphtheria is Still Here	112
Trustees' Meetings	131
Code for Physicians and Attorneys	134
Commentaries on Medico-Legal Code	135
Offices to be Filled by Election	137
Social Security Reports for Patients	137
Life Insurance Plan for Members	138
Committee on Aging	139
Diet Manual Committee	139
OBITUARIES	140
ANNOUNCEMENTS	142
COUNTY SOCIETY REPORTS	145
BOOK REVIEWS	149
NTA ABSTRACTS	151

Roster of Officers and Committee Chairmen, Advertising Page 3A

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36	77.00	39.30	48	136.00	69.40	60	315.00	160.70
37	80.00	40.80	49	148.00	75.50	61	330.00	168.30
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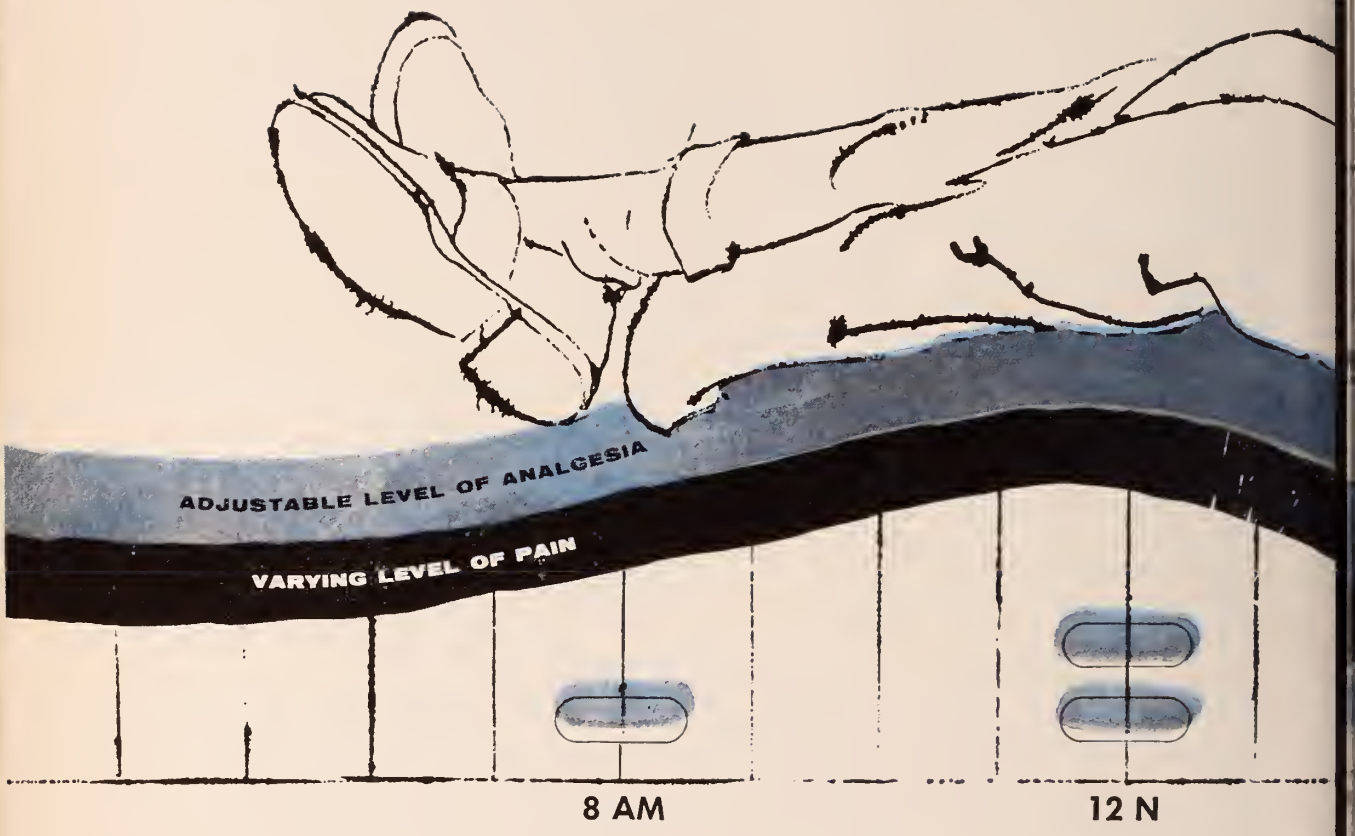
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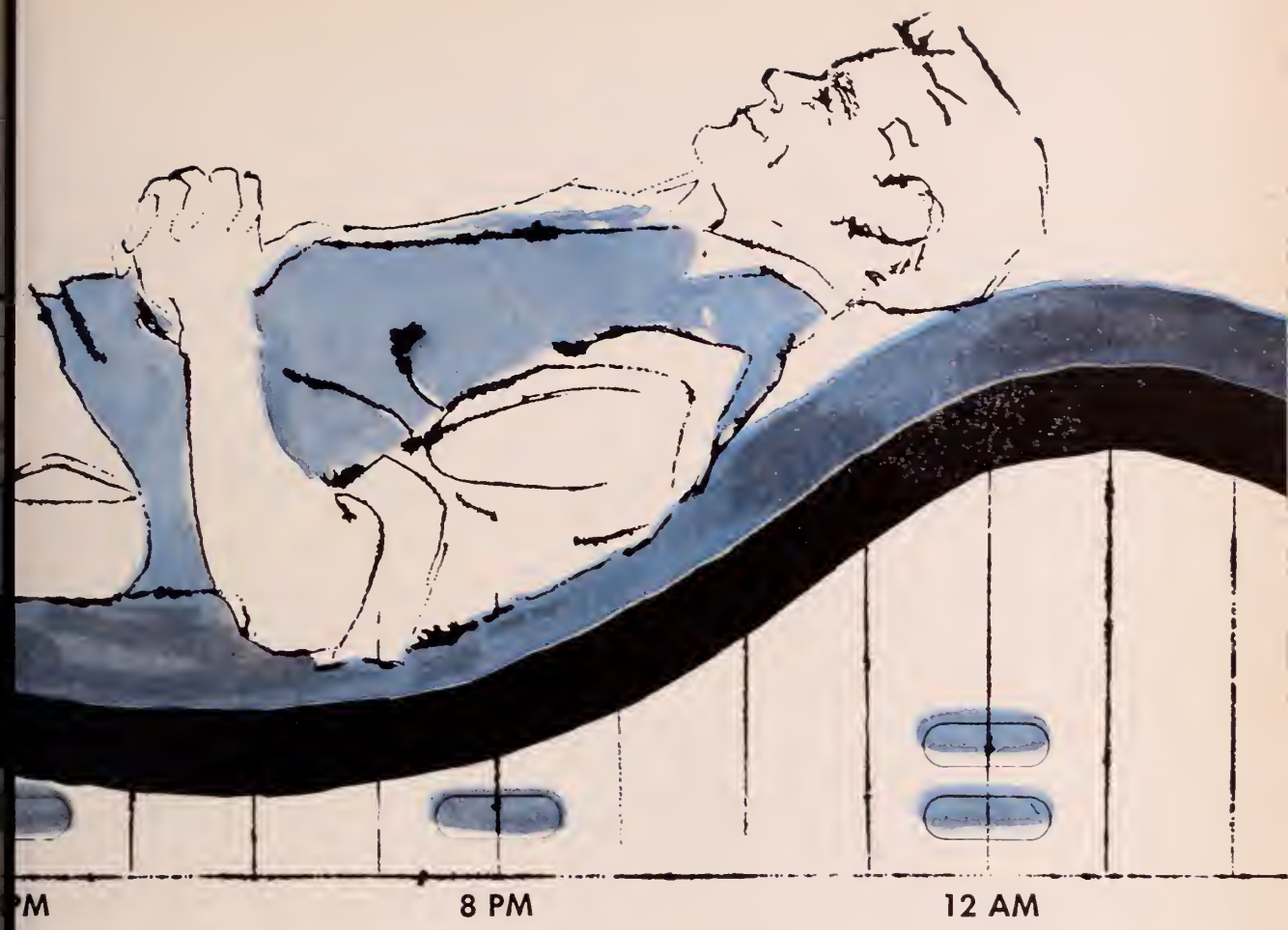
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Vitamin B_6	2 mg.
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in rheumatoid arthritis—"highly effective...in remarkably small daily milligram doses."[1]

The initial anti-inflammatory effect of DERONIL, the most active anti-rheumatic steroid on a weight basis synthesized to date,[1-4] is observed in most patients within 24 to 48 hours. Joint pain is relieved, swelling and stiffness diminish, and range of motion increases. The patient usually feels a sense of well-being and the appetite improves. The intensified anti-inflammatory activity helps assure successful initial therapy in rheumatoid arthritic cases and frequently restores relief to patients who have shown a diminution in response to previous steroids.

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Investigator or Study	No. of patients	Improvement		
		Very marked or marked	Moderate	Slight or inadequate
Boland, E. W., and Headley, N. E.[1]	11	4	5	2
Bunim, J. J., and others[3]	18	5	7	6
Series A[5]	15	4	9	2
Series B[5]	6	6	—	—
Series C[5]	3	3	—	—

DERONIL IN BRONCHIAL ASTHMA AND SEVERE RESPIRATORY ALLERGIES

Investigator or Study	No. of patients	Results		
		Excellent	Fair to good	Poor
Series D[5]	24	10	9	5
Series E[5]	12	8	3	1
Series F[5]	20	13	4	3

clinically preproved in steroid-responsive diseases

IMPROVEMENT WITH DERONIL IN A WIDE VARIETY OF ALLERGIC AND INFLAMMATORY SKIN DISEASES[5]

Disease	No. of patients	Improved	Same	Worse
Seborrheic psoriasis	1	1		
Neurodermatitis	5	5		
Allergic dermatitis	5	5		
Psoriasis	5	2	1	2
Lupus erythematosus, chronic discoid	1		1	
Atopic dermatitis	3	3		
Acne rosacea	1		1	
Nummular eczema	2	2		
"id" reactions	2	2		
Contact dermatitis	2	2		
Pityriasis rosea, severe	1	1		
Urticaria, chronic	1	1		
Totals	29	24	3	2

THERAPY WITH DERONIL IN A VARIETY OF INFLAMMATORY EYE DISEASES[5]

Patient, age and sex	Diagnosis	Symptoms	Results with DERONIL	Side effects
A.B., 46, M.	Postoperative uveitis		Improved; treatment being continued	None reported*
A.E., 53, M.	Choroiditis	Severe choroidal involvement	Excellent; marked improvement	None*
B.F., 60, F.	Acute choroiditis	Marked visual loss and choroidal effect	Marked improvement; therapy being continued	None*
B.K., 29, F.	Chronic uveitis	Generalized involvement	No change despite dosage increase	None*
H.K., 28, M.	Acute iritis	Blurred vision	Excellent; recovered	None*
A.P., 52, M.	Uveitis and perivasculitis	Vision loss to 20/80	Marked improvement; vision 20/30; treatment continued	None*
A.S., 34, M.	Uveitis		Excellent; patient recovered	None*

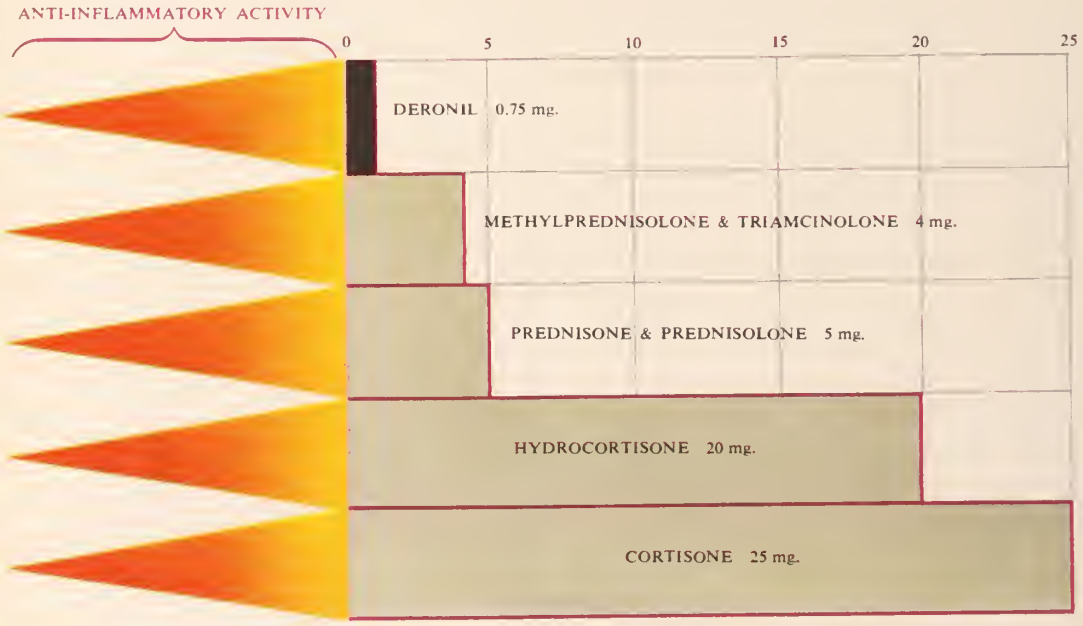
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Bibliography

(1) Boland, E. W., and Headley, N. E.: Preliminary clinical observations with a new series of synthetic corticosteroid compounds in patients with rheumatoid arthritis, Paper presented at Annual Meet., Am. Rheumat. Assn., San Francisco, June 21, 1958. (2) Boland, E. W.: California Med. *88*:417, 1958. (3) Bunim, J. J., and others: Arthritis and Rheumatism *1*:313, 1958. (4) Spies, T. D.; Stone, R. E., and Niedermeier, W.: South. M. J. *51*:1066, 1958. (5) Reports to Clinical Research Division, Schering Corporation.

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(1) Rubin, A., and Babbott, D.: J.A.M.A. *168*:498, (Oct. 4) 1958. (2) Kinsey, A. C.; Pomeroy, W. B., and Martin, C. E.: Sexual Behavior in the Human Male, Philadelphia, W. B. Saunders Company, 1948.

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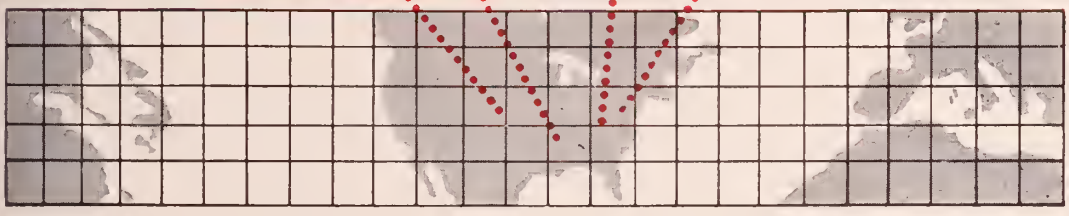
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For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

ATARAX®

Rx PFIZER

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.



FURADANTIN

brand of nitrofurantoin

PYELONEPHRITIS

"A DISEASE OF THE TUBULES"[1] as well as the glomeruli. In pyelonephritis, "the tubules suffer from damage to their lining cells which show cloudy swelling, granular degeneration and diminution in size. Inflammatory cells and colloid casts are found in the lumen of the tubules. . . . The glomeruli remain normal over a long period."[1]

in addition to simple glomerular filtration, FURADANTIN is actively excreted by the tubule cells.

FURADANTIN "may be unique as a wide-spectrum antimicrobial agent that is bactericidal, relatively nontoxic, and does not invoke resistant mutants."[2]

Available as Tablets, Oral Suspension

References: 1. Smith, I. M., and Lenyo, L.: Am. Practitioner 9:78, 1958. 2. Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. 95:653, 1955.

NITROFURANS—a new class of antimicrobials—neither antibiotics nor sulfonamides 

EATON LABORATORIES, NORWICH, NEW YORK ®

In potentially
seriou
infections..

*TRADEMARK, REG. U. S. PAT. OFF.

†TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF TETRACYCLINE

††TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

†††TRADEMARK

The Upjohn Company, Kalamazoo, Michigan

Make new

Panalba*

(ANmycin† Phosphate plus ALBAmycin**)

your broad-spectrum antibiotic of first resort

Effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:

Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains

Tetracycline phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride . . . . . 250 mg.
Novobiocin (as novobiocin sodium) 125 mg.

Panalba KM,†† Flavored Granules, 60 cc. size bottle. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

Tetracycline (tetracycline) equivalent to tetracycline hydrochloride . . . . . 125 mg.
Novobiocin (as novobiocin calcium) 62.5 mg.
Potassium metaphosphate . . . . . 100 mg.

Dosage.

Panalba Capsules. Usual adult dosage is 1 or 2 capsules 3 or 4 times a day.

Panalba KM Granules

For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 30 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the in-



BONADOXIN®

(tablets and drops)

STOPS STOPS STOPS MORNING SICKNESS



BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic...stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride .. 8.33 mg.
Pyridoxine hydrochloride ...16.67 mg.

Dosage:

under 6 months . . . . 0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years . . . . 1.5 to 2 cc.	
2 to 6 years . . 3 cc.	
adults and children over 6 . . . . . 1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, C. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

Rx only

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

for the control of all coccal infections



ABBOTT'S ANTIBIOTIC TRIAD

against staph-, strep- and pneumococci



After Millions of Prescriptions An Unparalleled Safety Record

Provides fast, high blood and tissue concentrations—Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes—and effective concentrations for at least six hours.

Supported by an unparalleled safety record—During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad spectrum" action, the normal intestinal flora is virtually unaltered with ERYTHROCIN therapy. And only recently, a well-known investigator said, "Erythromycin is by far the least toxic of the commonly used antibiotics.[1]"

Offers bactericidal action—Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal agent. It offers lethal action against common coccic invaders—resulting in prompt clinical responses.

Provides convenient dosage forms—Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also, in oral suspension and for intramuscular and intravenous use. Abbott

1. Herrell, W. E., Hazards of Antibiotic Therapy, J.A.M.A. [illegible]
*Filmtab—Film-sealed tablets, Abbott pat. applied for.

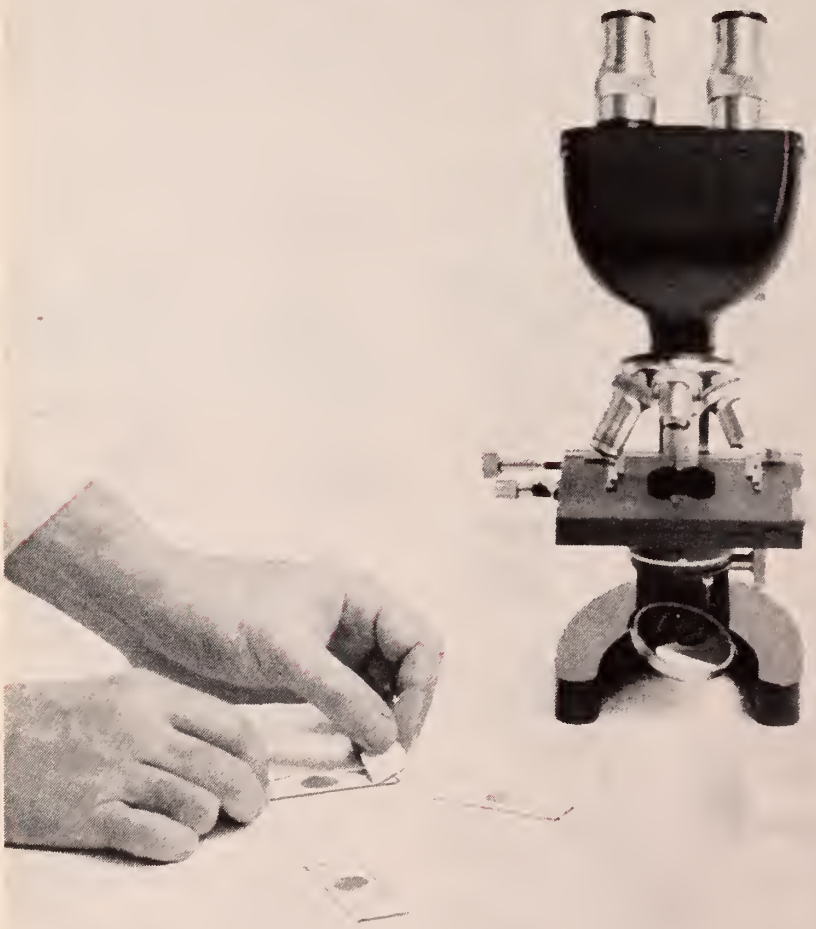
ERYTHROCIN STEARATE

(Erythromycin Stearate, Abbott)

an uncommon antibiotic

for common infections

for those penicillin-sensitive organisms



The Higher Blood Levels of Potassium Penicillin V

COMPOCILLIN-VK Indications—Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. As a prophylaxis in rheumatic fever and in rheumatic heart disease.

COMPOCILLIN-VK Dosage—Depending on the severity of the infection, the usual adult dose is 125 mg. to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

COMPOCILLIN-VK Supplied—In Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. For oral solution, COMPOCILLIN-VK comes in 40-cc. and 80-cc. bottles. When reconstituted with water, each appealing (it's a clear red solution) 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

Abbott

*Filmtab—Film-sealed tablets, Abbott; pat. applied for

COMPOCILLIN-VK

(Potassium Penicillin V)

in easy-to-swallow Filmtabs®

in tasty, cherry-flavored Oral Solution

against serious and resistant coccal infections



An Important Lifesaving Antibiotic

The dramatic story of SPONTIN can never really begin to be told.

In little more than a year, this potent antibiotic has compiled an incredible record for saving lives—and often, after all other therapy had failed. Majority of successes involved patients critically ill with staphylococcal infections—conditions that had resisted all other known antibiotic therapy.

Meanwhile, careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

So far, SPONTIN has proved to be a good answer, perhaps the best answer to the resistant staphylococcal problem—and of real value in other serious coccal infections.

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Crystallized

SPONTIN

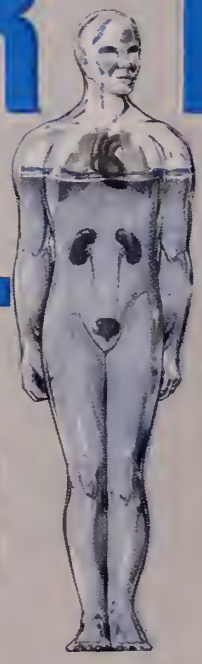
(Ristocetin, Abbott)

Prepared from pure crystals

Provides Outstanding Clinical Effectiveness Against Coccal Infections, Including Resistant Staphylococci and Enterococci[1]

Provides Bactericidal Action Against Coccal Infections[1]

WHATEVER THE ETIOLOGY—



EDEMA OF ANY DEGREE RESPONDS TO DIURIL®

CHLOROTHIAZIDE



An unparalleled record of safety and efficacy.

DIURIL has proved to be highly effective in overcoming edema associated with a wide variety of fluid retention states including: hypothyroidism, menopausal syndrome, allergy, peripheral phlebitis, arthritis, migraine headache, ascites or peripheral edema due to malignant tumor, and obesity. In the last case, Landes and Peters[1] achieved excellent to good results in nine obese patients in whom overweight was associated with moderate or severe fluid retention.

1. Landes, R. P. and Peters, M.: Postgrad. Med. 23:648, June 1958.

dosage: one or two 500 mg. tablets of DIURIL once or twice a day.

supplied: 250 mg. and 500 mg. scored tablets DIURIL (Chlorothiazide); bottles of 100 and 1000.

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any indication for diuresis is an indication for DIURIL

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IN OFFICE SURGERY

ELECTIVE AND TRAUMATIC

use XYLOCAINE *first...*
as a local anesthetic
or a topical anesthetic

SWAB SPRAY INFILTRATION NERVE BLOCK



Xylocaine HCl solution, the versatile anesthetic for general office surgery, relieves pain promptly and effectively with adequate duration of anesthesia. It is safe and predictable. Local tissue reactions and systemic side effects are rare. Supplied in 20 cc. and 50 cc. vials; 0.5%, 1% and 2% without epinephrine and with epinephrine 1:100,000; also in 2 cc. ampules; 2% without epinephrine and with epinephrine 1:100,000.

XYLOCAINE® HCl SOLUTION
(brand of lidocaine*)

Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

PDR

*U.S. PAT. NO. 2 441 498 MADE IN U.S.A.

More effective clinically

in LOW BACK PAIN

TORTICOLLIS

BURSITIS and

ANXIETY STATES

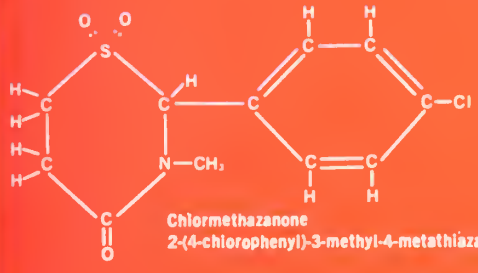
Trancopal

the first true tranquilaxant

Potent MUSCLE RELAXANT

and equally effective

as a TRANQUILIZER



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Unrelated chemically to any other therapeutic agent in current use. Better tolerated and safer than older drugs.

for clinical results in 4092 patients

see inside

Trancopal

the first true

*TRANQUILAXANT**

***Potent* MUSCLE RELAXANT**
***and equally effective as a* TRANQUILIZER**

clinical results in 4092 patients[5]

***tran-qui-lax-ant** (tran'kwi-lak'sant)
[< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

Clinical Comments

"We have just started using it [Trancopal] for relaxing spastic musculature and are *very much encouraged.*"[1]

Baker, University of Minnesota Medical School

"Chlormethazanone [Trancopal] not only relieved *painful muscle spasm,* but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

Lichtman, New York Polyclinic Medical School and Hospital

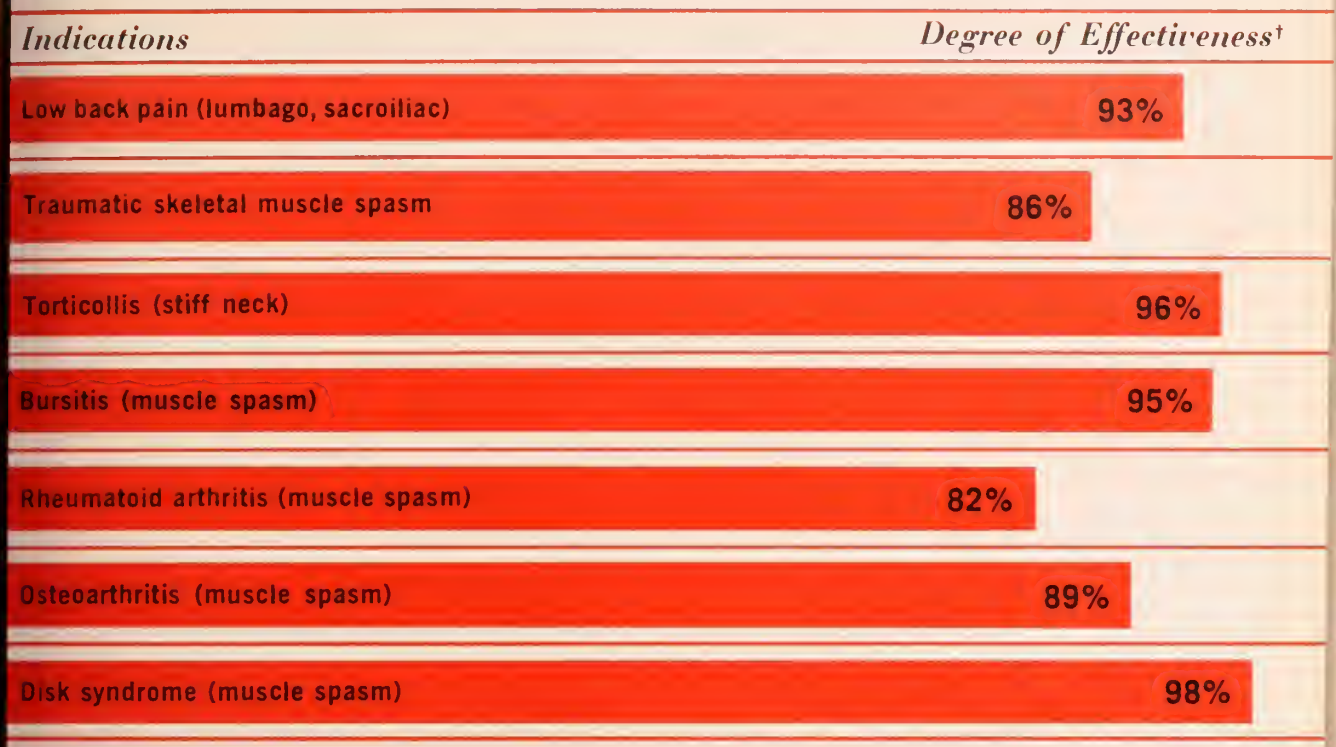
"The effect of this preparation in these cases [skeletal muscle spasm] was *excellent and prompt . . .*"[3]

Mullin and Epifano, Long Island College Hospital

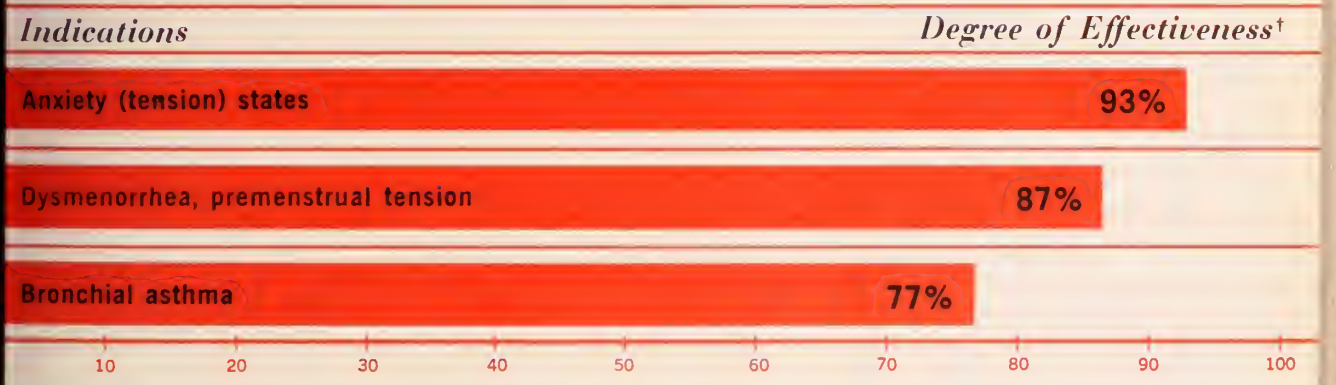
"In 120 patients with *anxiety or tension states,* 114 received satisfactory control of their condition. *Severe dysmenorrhea* and *premenstrual tension* in 65 patients refractory to the usual medications were relieved satisfactorily in 56."[4]

Lichtman

91% Effective in Musculoskeletal Disorders



89% Effective in Psychogenic Disorders



†*Excellent, good and fair*

The results of clinical studies of over 4092 patients by 105 physicians demonstrate that Trancopal often is effective when other drugs have failed. From these studies it is clear that Trancopal probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other pharmaceutical agent in current use.

Dosage:
Usual adult dose, 1 Caplet (100 mg.) three or four times daily. Children (from 5 to 12 years), ½ Caplet (50 mg.) three or four times daily.



Supplied:
Trancopal Caplets® (peach colored, scored) 100 mg., bottles of 100 and 1000.

Winthrop

Trancopal

the first true tranquilaxant

Potent MUSCLE RELAXANT *and equally effective as a* TRANQUILIZER

ADVANTAGES OF TRANCOPAL

- Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.
- No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- Low toxicity.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.
- No perceptible soporific effect, even in high dosage.

INDICATIONS

Musculoskeletal
Low back pain (lumbago)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disk syndrome
Fibrositis
Joint disorders (ankle sprain, tennis elbow, etc.)
Myositis
Postoperative myalgias

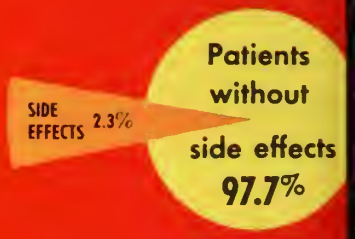
Psychogenic
Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris

Neurologic
Muscle spasm (in paralysis agitans, multiple sclerosis, hemiplegia, cerebral palsy)

SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4262 PATIENTS.

SUPPLIED

Trancopal Caplets (peach colored, scored) 100 mg., bottles of 100 and 1000.

REFERENCES

1. Baker, A. B.: Drugs to relieve increased tonus, spasticity and rigidity of muscles, Modern Med. 26: 140, April 15, 1958. • 2. Lichtman, A. L.: New developments in muscle relaxant therapy, Kentucky Acad. Gen. Pract. J. 4: 28, Oct., 1958. • 3. Mullin, W. G., and Epifano, Leonard: To be published. • 4. Lichtman, A. L.: To be published. • 5. Cooperative Study, Department of Medical Research, Winthrop Laboratories.

Winthrop Laboratories • New York 18, N. Y.

Trancopal (brand of chlormethazanone) and Caplets, trademarks reg. U. S. Pat. Off. Printed in U. S. A.

Now—All cold symptoms can be controlled



Provides Triaminic for more complete and more effective relief from nasal and paranasal congestion because of systemic transport to *all* respiratory membranes—without drawbacks of topical therapy.†

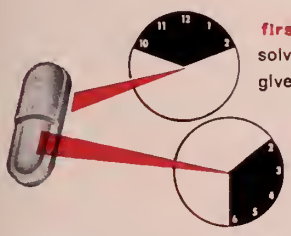
Provides well-tolerated APAP (N-acetyl-p-aminophenol) for prompt and effective analgesic and antipyretic action to make the patient more comfortable.

Provides Dormethan (brand of dextromethorphan HBr) for non-narcotic antitussive action on the cough reflex center in the medulla—as effective as codeine but without codeine's drawbacks.

Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

Special "timed release" design



first—the outer layer dissolves within minutes to give 3 to 4 hours of relief

then—the inner core releases its ingredients to sustain relief for 3 to 4 more hours

also available for those patients who prefer liquid medication: **Tussagesic suspension**

Each TUSSAGESIC tablet provides:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.
pheniramine maleate	12.5 mg.
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if needed.

Tussagesic* *timed-release tablets*

Contains* **TRIAMINIC *to* STOP *running noses and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

The Story of Kent

How Lorillard research produced a cigarette with less tars and nicotine than any other leading filter brand



A major research foundation, under Lorillard sponsorship, determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Further research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the superior Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. This is the "MICRONITE" Filter.

The Kent filter is composed of pure cellulose acetate, which is common to the filters used in all leading brands. However, the physical construction of the Kent filter is the exclusive development of Lorillard research, and is different from and superior to all the rest.

Thus, Lorillard research created a filter of ideal purity, with extraordinary ability to eliminate smoke particles... and at the same time, a cigarette of such fine taste that during the past twelve months more smokers changed to Kent than to any other cigarette in America.

Of all leading filter cigarettes

KENT FILTERS BEST

You get less tars and nicotine in the smoke of Kent than in any other leading filter cigarette in America

If you would like for your own use the booklet, "The Story of Kent," write to:

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200 East 42nd St., N.Y. 17, N.Y.

in skin disorders

Decadron*



DEXAMETHASONE

treats more patients more effectively
a new order of magnitude in corticosteroid effectiveness
a new order of magnitude in margin of safety

Striking clinical results with DECADRON are reported† in 92 percent of 319 patients with dermatological disorders, including cases previously unresponsive or resistant to corticosteroids. There were no major complications, and even minor side effects occurred in less than eight percent of patients.

Moreover, in many cases reactions induced by previous steroid therapy, such as edema, Cushingoid appearance, headache, vertigo, muscular weakness, depression, hirsutism, and glycosuria, **disappeared during therapy with DECADRON.** †Analysis of clinical reports.

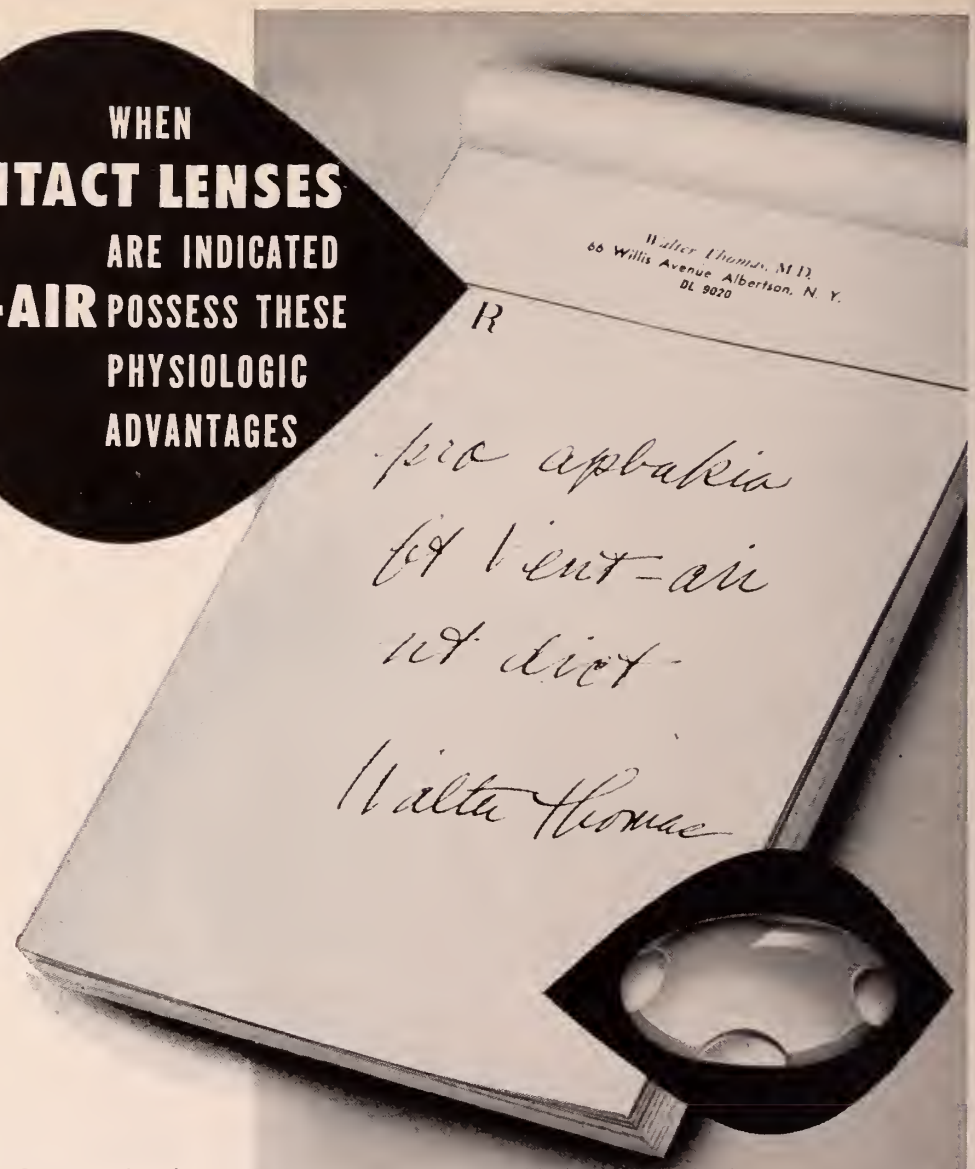
Dosage: One 0.75 mg. tablet of DECADRON will usually replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100 and 1000.

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WHEN CONTACT LENSES ARE INDICATED VENT-AIR POSSESS THESE PHYSIOLOGIC ADVANTAGES



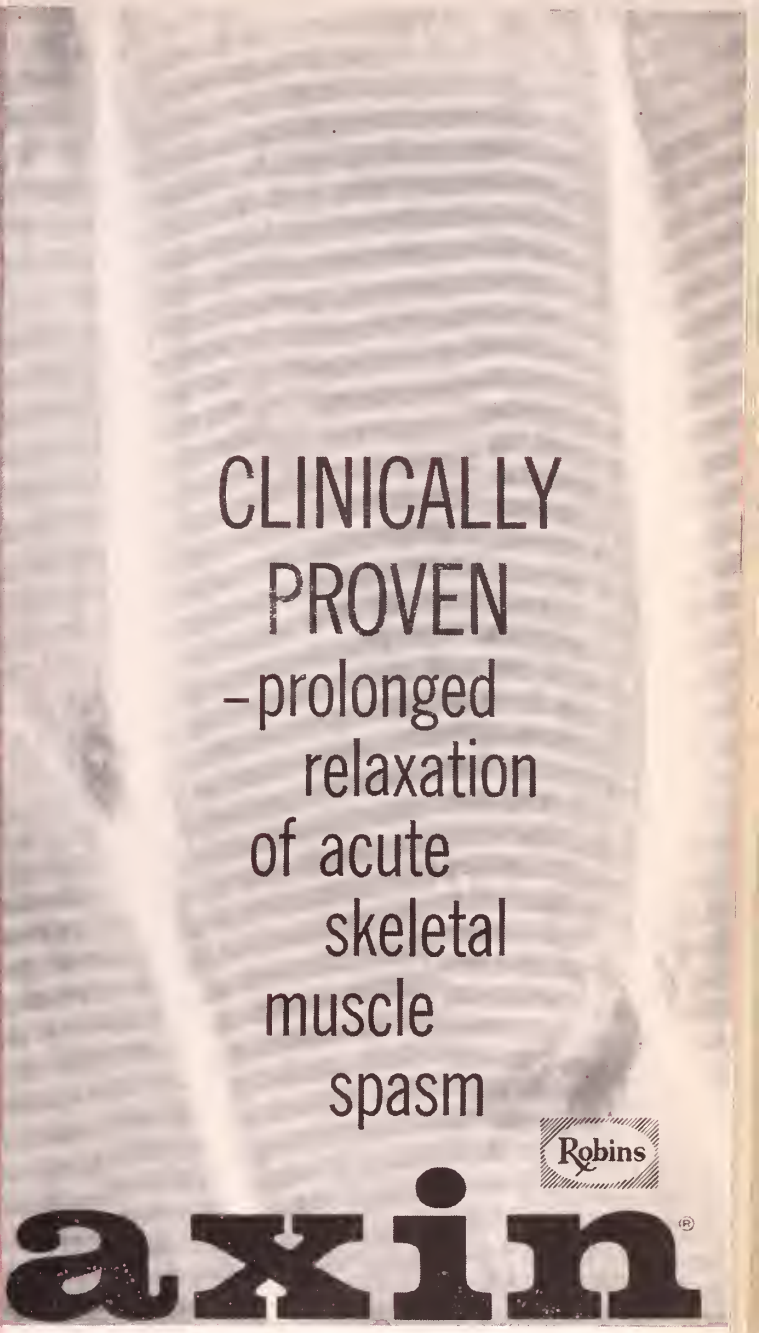
Four peripheral vents	Permit topical circulation of lachrymal and glandular secretions without excessive motility
Corneal apical clearance	Favors normal corneal metabolism and oxygenation
Ultra-Smoothness of Inner and Outer Surfaces	Avoid limbal epithelial and tarsal conjunctival exacerbation
Highly absorptive methyl-methacrylate composition	Simulates "wetting" and moisture-retention properties of cornea (of military specification)
Precision-ground	Prescriptive qualities exact to ± 0.12 D. with precise allowance for vertex refraction and lachrymal factor (exact to .02 mm radius in inner curvature)
Custom-fitted	In uni-, bi-, or tri-curve radii conforming to corneal peripheral asphericities
Hyper-thinness of edge or center	Maintains uniform thickness in high myopia or hyperopia approximating .20 mm irrespective of power
Widest range of inner radii	From 5.0 to 10.00 mm providing for extremes of keratoconic and megaloglobic dimensions
Cosmetic, pin-hole and tinted effects	For leucomatous, polyopic, iridodialytic and albinic conditions or other corneal or media anomalies.

VENT-AIR CONTACT LENS LABORATORIES • NEW YORK, N Y

Fiber of skeletal muscle in spasm

Fiber of skeletal muscle relaxed *(photomicrographs)*





CLINICALLY PROVEN –prolonged relaxation of acute skeletal muscle spasm

Robins

Robaxin®

Methocarbamol Robins U.S. Pat. No. 2770649

TABLETS

Summary of six published clinical studies:

ROBAXIN BENEFICIAL IN 92.4% OF SKELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[1]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
		"excellent"			
O'Doherty & Shields[4]	17	14	2	1	0
		"significant"			
Park[5]	30	27	—	2	1
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184	34	4	14

- Highly potent—and long acting.[1,2,3]
- Relatively free of adverse side effects.[1,2,3,5,6]
- In ordinary dosage, does not reduce muscle strength or reflex activity.[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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STEREOFONIC HIGH-FIDELITY

new listening luxury for your home!

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Listen to new stereofonic music on a Webcor! You'll hear music with all its glorious tones and dimensions . . . all about you! This is listening enjoyment at its finest . . . *on a Webcor!*

See and hear the Victorian now . . . plus the complete new Webcor line for '59!



Victorian Stereo-Fidelity Radio-Fonograf plays stereo and monaural records. It features "Magic Mind" Stereo-Diskchanger, three speakers, and 15-watt amplifier, sensitive 13 tube AM-FM radio-fono combination. In hand-rubbed Mahogany. Only **$319.95.** Maple (slightly higher). Without radio **$229.95.**

Stereo Mate I—Matching external Amplifier-Speaker system for the Victorian Console. Mahogany, **$79.50**. Maple (slightly higher).

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MILD MODERATE SEVERE

DIUPRES*

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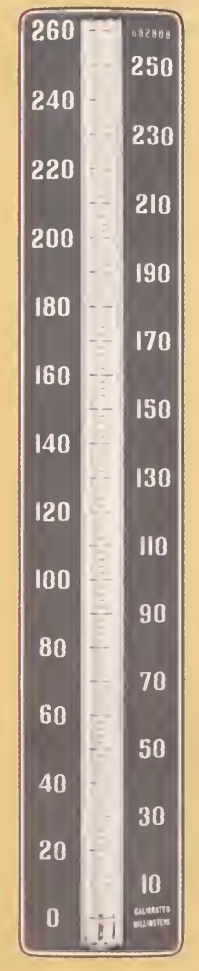
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. . . with greater simplicity and convenience

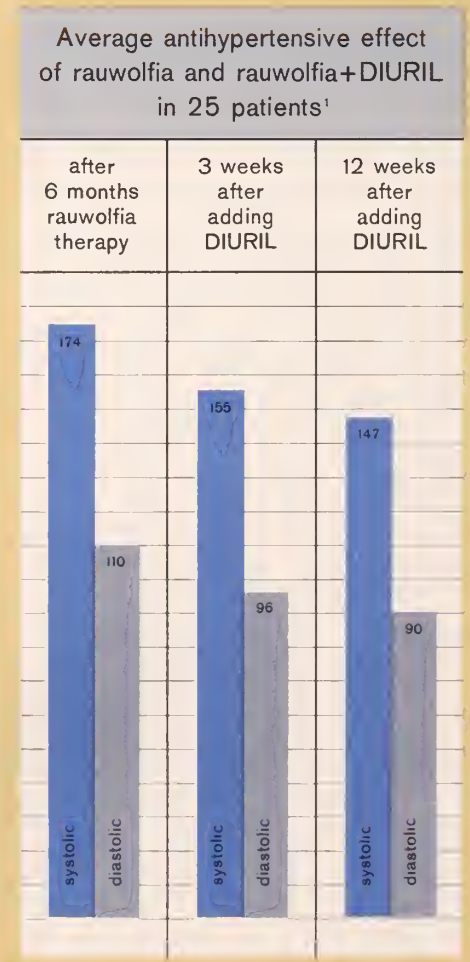
a logical alliance of two antihypertensives you know and trust provides

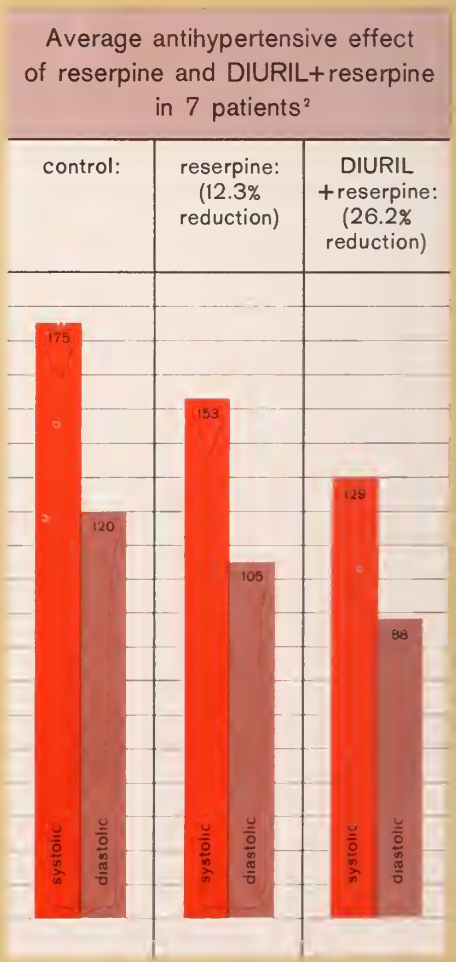
increased effectiveness, decreased side effects

potentiated effect

DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.







DIUPRES

DIURIL® WITH RESERPINE

effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet provided this gives approximately the correct dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

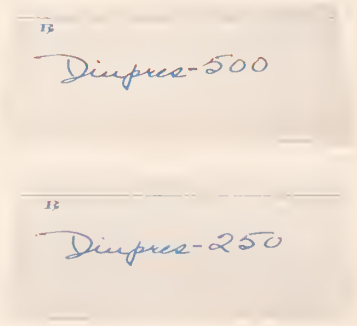
Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.

If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

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1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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in cases of tension

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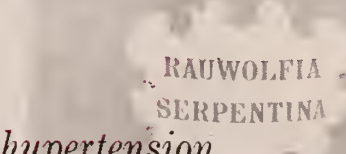
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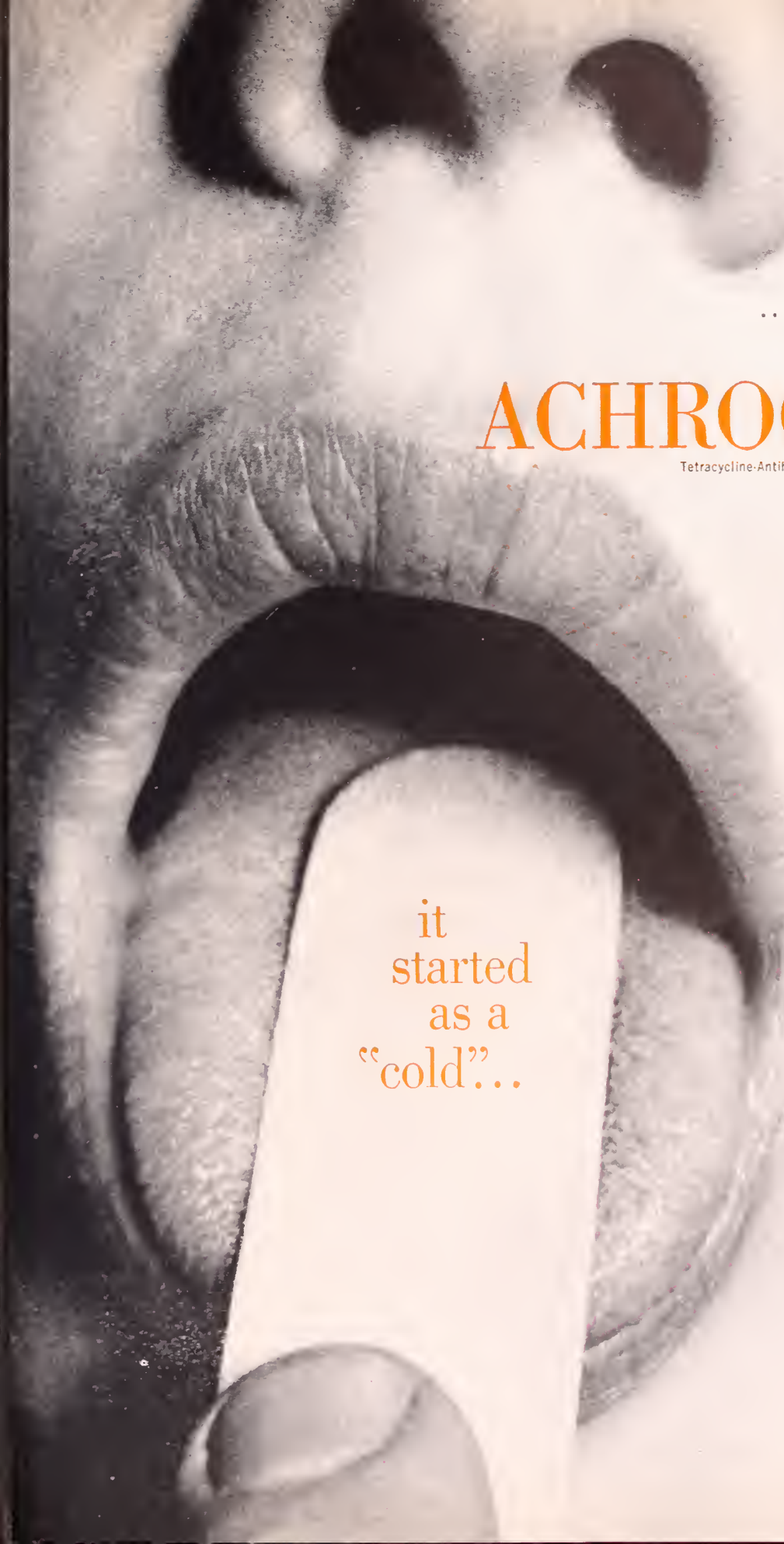
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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1. Levy, S.: J.A.M.A. 153:1260, 1953.

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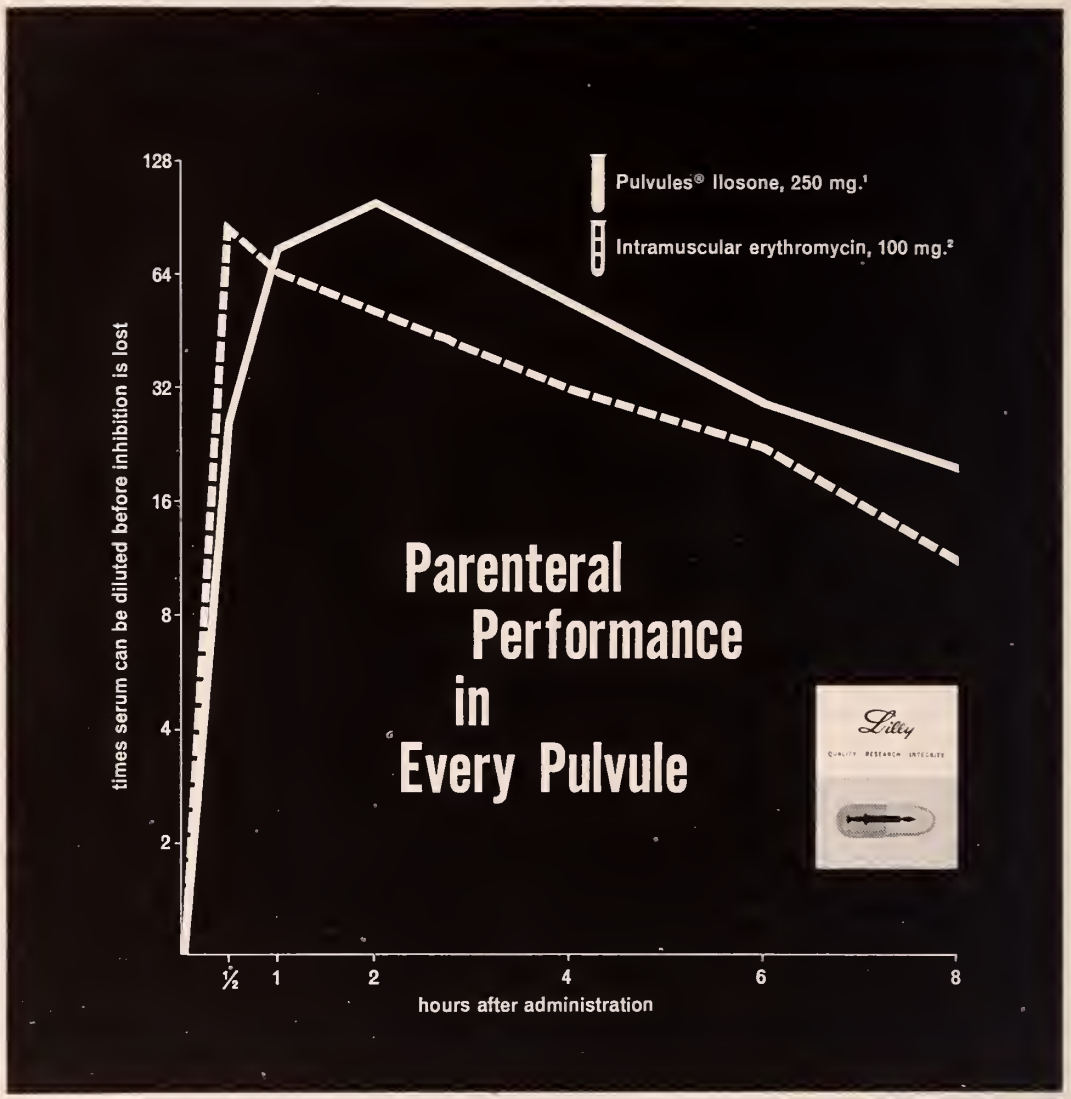
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1. Antibiotic Med. & Clin. Therapy, 5:609, 1958.

2. Data from Antibiotics Annual, p. 269, 1954-1955.

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Editorials • • •

Liability and Progress

Without venture, without risk, there would be no progress in medicine. What brave soul was the first to try an intravenous injection, open the thoracic cavity, apply a new unguent? When Crawford Long and William Morton first poured ether over a human nose, they ran a risk. Had they given too much, a dead patient would have destroyed their reputations. Had they given too little, a jeering audience would have humiliated them. Had they failed, all surgical science would have been set back many decades. Most of us in medicine are followers—we have to be—and try only those treatments which are recognized. But we followers do not push medical science ahead. That remains the glory—and the risk—of the few scientists who will take a chance.

These observations are prompted by a recent decision in a California court awarding damages to two children who developed poliomyelitis after receiving vaccine. The jury agreed that the manufacturer was not negligent. But they felt that somehow the untoward results spoke for themselves. The child became sick—the injection caused the sickness—therefore the maker of the vaccine was liable. It could just as well, by this reasoning, have been the giver who was liable. And the giver could be any physician or dentist.

Thus is established the terrifying doctrine of absolute liability. By this concept, the doctor is liable for whatever bad results flow out of his work. To protect himself, he must use only old methods. He uses something new at his own risk. The American College of Physicians, in an *amicus curiae* brief, put it very aptly in these words:

"Under such a doctrine . . . physicians would be afraid to avail themselves of new drugs; pharmaceutical houses would not be willing to manufacture new products should this concept be applied, for it holds the defendant liable without fault and liable for the unknown.

"Since the fact is self-evident that certain treatments will save lives or alleviate suffering, it is unrealistic to say that there must be no unknown untoward effects. Neither manufacturers nor insurance companies can afford to insure against the unknown and the unpreventable. Thus, the life-saving drug or biological that may save thousands of lives every year from cancer which might

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be available tomorrow would probably, under the absolute liability situation, be withheld for another ten years of testing and 'wait and see' and 'make sure' periods. To be sure, a statistically small number of hypersensitive or hypersusceptible individuals will thus be saved from harm. In the meantime thousands who might otherwise live, or live without suffering, will necessarily be denied medical care.

"How can any scientist, physician, hospital or pharmaceutical producer become involved in any forward steps in medicine, no matter how surrounded by standards, if he is to be held responsible for knowledge that does not, and cannot, exist until the future unfolds?"

If this decision stands, it makes caution dominate over creative intelligence and throws sands in the machinery of progress. It adds one more risk—an incalculable one—to the day by day practice of medicine. We all await with interest the result of the appeal. One cannot, with good grace, comment on the legal nuances of the case. But this is certain: no matter how sound the legal technicalities, the doctrine of absolute liability will seriously set back the cheerfully ticking clock of medicine.

Competition in the Drug Industry

More than 1000 pharmaceutical companies manufacture drugs for our use.* That means a lot of competition, jostling and duplication. Theoretically, it would seem smarter to consolidate these companies into a single drug-making unit that would save millions in overlapping costs and avoid duplication of effort. Yet if this were ever done, it would be a massive blow to public health. The competitiveness of the drug industry—which is a drag on the industry's profits—is a boon to our patients and to ourselves.

The most dramatic effect of this competition is the way it keeps prices down. With all good companies making drugs that conform to standard, no one is going to buy Tradename X at 4 cents a capsule when Tradename Z sells at 2½ cents. So competition forces down the price, benefitting our patients. More than that, competition compels companies to search for different and better ways of preparing an item. If Company A has a patent on a process, Company B cannot get into the act unless its chemists find an equally good but basically different process. So competition spurs Company B's efforts to improve the technic; and Company A, anxious to remain in the running redoubles its efforts. Then, too, competition rapidly makes drugs obsolete. If one manufacturer produces a fine antibiotic with only 3 side-effects, his competitor works to manufacture one with no side-effects. Result: the first antibiotic becomes as obsolete as tincture of gentian. This plays havoc with drug profits but it keeps the best pharmaceuticals in front of the shelves.

Every good company competes with itself. One chemist sweats for years to manufacture a new drug only to see his colleague across the room make it obsolete by finding a better product. Then, too, competition prevents a company from becoming self-satisfied. No pharmaceutical manufacturer can ever rest on his oars.

So let Europe have its cartels, and Russia its state monopoly. We'll take a thousand fiercely competitive companies duplicating each other's efforts, driving each other's prices down, and striving mightily to win the blue ribbon of the most effective, least toxic drug of its kind. It is no coincidence that competitive American drug enterprise has given us the finest pharmaceuticals in the world.

*Weilburg, John: Bulletin of the Los Angeles County Medical Association, May 15, 1958.

HAROLD M. FISCHER, M.D.

East Orange

RALPH ROSAMILIA, M.D.

Newark

Survival After Three Potentially Fatal Surgical Complications*

When all hope seems lost and all our weapons seem feeble, it is good to remember that sometimes a human being is resilient enough—with an assist from a good doctor—to come back even after three often-fatal assaults.

This case report concerns a 43 year old male who survived three complications of surgery each of which alone carries a high mortality rate. Following an emergency laparotomy for relief of intestinal obstruction due to postoperative adhesions, he survived cardiac arrest with a mortality rate of 50 to 85 per cent,[1,2,3] delirium tremens with a mortality rate of 5 to 15 per cent,[4] and abdominal wound disruption with a mortality rate of 15 to 35 per cent.[5,6,7] This case represents an amazing recovery due to prompt effective surgical and medical attention. We readily acknowledge that another "non-medical force" was also in attendance.

A 43 year old man was admitted to Martland Medical Center on July 15, 1957 with a history of insidious onset of colicky peri-umbilical pain beginning 18 hours earlier. Commencing one hour after the onset of pain he vomited 8 times before admission to the hospital and had 4 watery bowel movements. The pain was intermittent at the onset, but had become continuous and intense by the time of admission. Its location remained unchanged and without radiation. There was no history of hematemesis, melena, or black stool. There was no history of diarrhea or constipation. He admitted to a heavy alcohol intake during the previous 24 hour period and a greater than normal daily use of alcoholic beverages. One year earlier he had had a cholecystectomy for cholecystitis with cholelithiasis, but had been asymptomatic since.

He was a well developed, poorly nourished man, obviously in acute distress. There was no odor of alcohol on his breath. Blood pressure was 170/110. Pulse was 92 and regular. Respirations were 34. There was a moderate dryness of the oral membranes and tongue. His abdomen was moderately distended and revealed an oblique scar in the right upper quadrant. He showed diffuse tenderness, rebound tenderness, and rigidity. There was tympany throughout and hyperperistalsis was noted.

X-rays of the abdomen on admission revealed veiling, air-fluid levels in the small bowel, normal

*From the service of Dr. William Crecca, Martland Medical Center, Newark.

1. Dale, W. A.: Cardiac Arrest. Ann. Surgery, 135:376 (1952).

2. Henchey, P. and Straehley, C. J.: Cardiac Arrest in the Operating Room. New England J. Med., 247:1003 (1952).

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5. Maingot, R.: *Abdominal Operations.* New York, Appleton-Century-Crofts, 1955.

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large bowel, and absence of free air under the diaphragm. The chest was normal.

Laboratory testing revealed the following: hemoglobin 12.8 Gms., WBC 9,700, neutrophiles 93 per cent, serum amylase 206 U., BUN 14. CO_2 combining power was 31 per cent. Chlorides 103 mEq. urine: S.G. 1.027, few RBC and WBC. Albumin one plus.

Therapy was begun with the passage of a Miller-Abbott tube, administration of intravenous fluids and electrolytes, and antibiotics.

The patient was observed carefully while on Wangensteen suction. Some two litres of electrolyte solutions were given during the first 6 hours. Eight hours after admission, his status was unchanged except that he was better hydrated. A decision to do a laparotomy was made on the basis of a diagnosis of intestinal obstruction due to postoperative adhesions.

Under spinal anesthesia, the laparotomy began at 9:40 p.m. A right upper muscle splitting incision was made through the old scar. Numerous adhesions were found to the old operative site. Examination of the small bowel revealed distention of ileum and jejunum proximal to the obstruction. There was no evidence of acute pancreatitis. The adhesions were lysed and the continuity of the intestinal stream re-established. All bleeding was controlled and the peritoneal closure was begun at 10:35 p.m. Five minutes later, he became confused and disoriented. At 10:35 p.m. as the anterior layer of the rectus sheath was being closed the anesthetist announced the absence of a pulse or blood pressure.

Thoracotomy was done immediately through the third left intercostal space. The heart was palpated and found in a state of asystole. It was massaged against the sternum 10 times before a single spontaneous contraction occurred. The heart was again massaged and after several seconds regained its normal rhythm. The chest was then rapidly closed as well as was the remainder of the abdominal incision. During the period of cardiac massage Neosynephrin 1 per cent was given intravenously. At this time blood pressure was 105/65 and pulse 100 and regular. The patient again regained consciousness and appeared coherent. The blood pressure was maintained at 140/110 with a slow drip of Levophed® solution for 2 hours after which time it could be discontinued. He was given Combiotic® and placed in an oxygen tent. Emergency ECG revealed sinus tachycardia with T wave changes suggestive of myocardial ischemia.

The patient did well until noon of the first postoperative day when he began hallucinating. He broke heavy restraints and was found wandering about the corridors. He was returned to bed and found to have a temperature of 103. Gross tremors were also observed. The diagnosis of delirium tremens was made. For the next four days he received 75 milligrams of promazine intramuscularly every 4 hours, alcohol solutions intravenously, insulin-glucose "cocktails," B-complex, and occasional doses of paraldehyde. He spiked a temperature 101 to 103 degrees F. until the fifth day when he became afebrile. His intake-output and electrolyte levels were maintained satisfactorily. Chest x-ray on the third day was negative.

On the sixth postoperative day some sero-sanguinous drainage was noted on the abdominal dressings, however, the wound appeared intact. The next day the lower end of the wound separated. The patient was brought to the operating room and under spinal anesthesia the wound was closed with through and through black silk sutures. Within two days peristalsis returned and he started on oral feedings with high doses of vitamins and protein supplements. The sutures were removed on the twelfth day and the wound appeared healed. He became ambulatory on August 4 and, feeling "very strong," he was discharged on August 6.

This patient was followed for three months postoperatively without clinical evidence of cerebral or cardiac disease. At his last visit to the clinic his wound was healed well and he was advised to return to full time employment.

10 First Avenue

Monkeys Can Get Ulcers

Monkeys that are given executive responsibilities often develop ulcers. So it says in the June 1958 *Current Medical Digest* (25:60) in a report by John Tilden Howard. They give executive responsibilities to monkeys by entrusting one monk with the duty of pressing a lever to protect another animal from an electric shock. Monkeys entrusted with this responsibility developed peptic ulcers, while the passive partner did not.

Thomas M. Kain, Jr., M.D

Camden

Rheumatic Fever Prevention*

Results of a Two-Year School Program

Can the mind of man, which cracked the secrets of the atom, also develop a way of preventing rheumatic heart disease? Here is a blow-by-blow description of an ambitious program with this aim.

The prevention of rheumatic fever is related to the eradication of the so-called "streptococcic sore throat." The role of the beta hemolytic streptococcus infection of the nasopharynx and its relation to rheumatic fever was first clearly demonstrated in 1931 by Coburn.[1] Numerous surveys have since corroborated Coburn's concept by demonstrating the occurrence of rheumatic fever following outbreaks of scarlet fever [2] and other streptococcal infections.[3] Further evidence relating the streptococcus to rheumatic fever developed when a great reduction in the incidence of rheumatic fever occurred after treatment with antimicrobial drugs.[4,5,6,7] As of this date, rheumatic fever throughout the country continues to steadily decline.

When the Camden County Heart Association came into existence in 1954, it formed the Rheumatic Fever Committee. This paper concerns itself with our experiences and conclusions in detecting the group A, beta hemolytic streptococcus in one of the elementary public schools in Camden. We used the Youngstown, Ohio, plan as a format.[8] Our program was instituted as a field trial. I felt we could render a great service to the community and to our children if such a project was found to be workable at reasonable cost. As a result, we decided upon a school where we knew we would enjoy the full cooperation of teachers, parents and pupils. There were 550 children in the Parkside School, between the ages of 5 and 12 years, from kindergarten to Grade 6. We received full support from the Board of Education of Camden, the City nurses, the Camden Visiting Nurses Association, the teachers, parents and pupils. Physicians were the hardest to convince. Conferences were held at the Parent-Teacher Association meetings, before, during and after the program was instituted. Literature was distributed as freely as possible, though somehow several parents escaped notice. The physicians were instructed by literature, announcements in the *Bulletin* of the Camden County Medical Society and at an open meeting. Treatment cards were distributed to all doctors in Camden County. This preliminary phase consumed the spring, summer and fall of 1955. We began in January, 1956. Cultures were taken on all children who had any signs or symptoms of an upper respiratory infection. The throat swabbing was done by the school nurse and by a member of the Visiting Nurses Association, daily for 5 days. The correct swabbing technic was demonstrated by a physician-member of our committee to all school nurses, health nurses and visiting nurses. The mem-

*Presented May 20, 1958 at the Annual Meeting of The Medical Society of New Jersey.

bers of the Parent-Teacher Association arranged a car pool for swift transportation of the culture tubes to the Laboratory of the city's Health Department at the Municipal Hospital, under the direction of Dr. Louis Coriell. Culturing was done by Mrs. Elizabeth H. Kauderer. When a positive culture occurred, an oral report was called to another physician-member of the committee, who notified the family physician. A written report, along with a treatment card was promptly sent to each doctor. We kept the children with positive cultures out of school for 10 days, thinking this would insure adequate treatment. However, we found that this was not the case and discontinued the procedure the following year. No children were allowed to return with a positive culture. The positive children were recultured in 10 days and again every month for 3 months. In this way we hoped to gain information concerning re-infection and effects of treatment.

During the 9 months of the 1956-7 school year, we found it necessary to employ a full-time visiting nurse. We then expanded the program to include the culturing of non-symptomatic children for carriers, home and family cultures. We cultured 103 children from Grades 2, 3 and 4 at least once a month. The symptomatic program (with exception of periodic follow-up cultures) remained the same. The nurse worked five days a week. There were no week-end cultures. During this year, the enrollment was 530 children.

One of the difficulties encountered in the various other programs was the accurate identification of the group A, beta hemolytic streptococcus. It is reported that the Hemophilus hemolyticus, the hemolytic staphylococcus and certain gram negative cocci will produce similar hemolysins.[10] The culture technic, outlined below, conforms closely to that described by Wannamaker.[10] Sheep's blood was used for comparison with growth on human blood. The technician found the colonies too small for accurate recognition and eventually sheep's blood was discontinued. No serological typing was employed.

METHOD AND TECHNIC FOR IDENTIFICATION OF GROUP A STREPTOCOCCUS

1—Swabs were taken from the throats and placed in a milliliter of soy broth and brought to the laboratory within the hour.

2—Cultures were streaked on blood agar plates, using 5 per cent human blood. Poured blood agar plates were also made, using 5 per cent sheep blood. The plates were incubated for 24 hours.

3—Plates were examined by microscope for characteristic beta hemolytic colonies.

These characteristics: (1) From broth, were Gram positive spherical or ovoid cells in long chains. (2) From blood agar plates — small colonies 0.5 to 0.75 millimeters, Gram positive, opaque, slightly raised, circular with entire margin of clear, colorless zones of hemolysis 2 to 4 millimeters in diameter, under the microscope. No red blood cells seen within this zone.

(a) If these micro-organisms were Gram positive, a tentative report was given as Beta Streptococcus.

4—Characteristic Gram positive colonies producing beta hemolysis were picked to broth and streaked on blood agar with 1 microgram disc of bacitracin and incubated for 24 hours. A final report was then given as Beta Streptococcus, sensitive or resistant to bacitracin.

This is the procedure of Maxted [9] who found a significant proportion of the Group A, Beta Hemolytic Streptococcus to be sensitive to bacitracin.

In 1956 there were 108 children with 22

TABLE 1.

SYMPTOMATIC

Year	Enrollment	Number of Children	Neg.	Pos.	Number of Cultures	Initial Cultures	Repeat Cultures	Neg.	Pos.
1956 5 mo's	550	108	86	22	198	108	90	173	-22 I.P. 25 -3 R.P.
1956-57 9 mo's	530	250	219	31	562	250	312	517	-31 I.P. 45 -14 R.P.

positive; 198 cultures were performed, of which 22 were positive with 3 repeat positives. In 1957 there were 250 children with 31 positive. 562 cultures were performed, 31 were positive with 14 repeat positives (Table 1).

From the mass culturing (Table 2), we found as many positive children as there were in the 1956 symptomatics and a higher proportion than in 1957. If mass cultures were done on the entire enrollment, the incidence of positive cultures would undoubtedly have been higher. No symptomatic children in 1956 were found in the mass program.

According to grades (Table 3), the top incidence of positive cultures was found in grades 2, 3, 4 and 5. This was the reason for using these grades in the mass program. The highest months were March, April and May. The three repeat cultures in 1956 were done on one child who received no treatment until after the second culture. Another child had inadequate treatment and the third received 12 doses of penicillin, totaling 3.6 million units. Three months later, on routine culture, she again was positive. The same dose of penicillin was administered. In 1957, this child returned 2 positive cultures. We could not get accurate data about the treatment the "repeat-positive" children received in 1957. One child was discovered who received insufficient initial treatment and became negative with adequate penicillin. We discovered that all the "repeat-positive" children had insufficient treatment. The positive throats that received the recommended treatment, according to the American Heart Association, remained negative on follow-up cultures. There were 5 children who were positive in 1956 and again in 1957; one child from grade 1, one from grade

TABLE 2.

MASS

Year	Enrollment	Number of Children	Neg.	Pos.	Number of Cultures	Initial Cultures	Repeat Cultures	Neg	Pos.
1956-57 9 mo's	530	103	82	21	594	103	491	567	-21 I.P. 27 -6 R.P.

TABLE 3.

POSITIVE CULTURES

	Symptomatic				Mass	
Year	1956		1957		1957	
Class	Initial	Repeat	Initial	Repeat	Initial	Repeat
Kindergarten	1	0	4	1	..	..
First grade	1	0	4	1	..	..
Second grade	8	2-2 child.	4	5 (-1 child (3 times (-1 child (2 times	7	5 (-1 child (3 times (-1 child (2 times
Third grade	3	0	8	5 (-1 child (3 times (-2 child. (1 time	8	0
Fourth grade	6	1	3	2	6	1
Fifth grade	1	0	7	0	..	..
Sixth grade	2	0	1	0	..	..
Total	22	3	31	14	21	6

TABLE 4.

PER CENT POSITIVE

Program	Camden, N.J.	Miami, Fla.[11,12,14]	Youngstown[8] Ohio	Casper[15] Wyo.	Mercer Co.,[17] Pa.	Denny[13]
Symptomatic	5 Mo's - 9 Mo's	5 Mo's - 8 Mo's	9 Mo's	9 Mo's	9 Mo's	
Children	20.3 - 12.4	.....	8	15.9	18.7	
Cultures	12.3 - 8.0	.....	6	6.0	..	
Mass				11 days		
Children	20.4	16.3 14.0		2.6		5-10
Cultures	4.5	6.2 11.4	..	...		

2 and three from grade 4. In 1956, one child developed acute glomerulonephritis. There was a case of scarlet fever in 1957 but a culture was not done until after return to school. There was a suspected case of rheumatic fever in 1957.

The proportion of positive children and cultures is compared with other plans in Table 4. The high incidence of positive children in the mass program indicates the Beta Streptococcus is carried in the nasopharynx more frequently than suspected. It takes many more cultures to detect these children. The percentage in the two years reflects the number of children examined and probably more precise laboratory identification.

The home and family culturing portion of the program was not well accepted by the parents. Most of the sibling cultures were done in school. We did not obtain a single positive home culture, which is entirely out of accord with findings in other programs. Positive home cultures are reported[15] as high as 31 per cent. During the first year all children received some type of penicillin but only 46 per cent the recommended treatment. During the second year, 16 doctors answered 29 questionnaires; and of these, 32½ per cent of the children received adequate treatment. This could account for the high number of "repeat-positive" cultures in 1957. The cost of the program for 1956 was approximately $1.33 per child, then for 1957 was $6.68 per child. This figure excludes any technician's fee.

It becomes obvious that the so-called "streptococcic throat" cannot be accurately diagnosed by signs and symptoms. The high incidence of the beta hemolytic streptococcus in the nasopharynx without symptoms is being discovered throughout the country.[14] It is impractical and financially impossible to carry out such a program in every school. The best approach for protecting the rheumatic child is the prophylactic administration of penicillin. To prevent epidemics and complications of the streptococcal sore throats, it behooves all physicians, and particularly pediatricians, school physicians and nurses to take throat cultures on adults and children when indicated. A practical method is currently in use by the Board of Health Department in the city of Chicago.[14] (See below) The plastic culture plates cost about 50 cents each. The cards are concise and easy to complete. The physicians are notified by phone and mail. This method of attack should be very effective. It is illustrated below.

CHICAGO BOARD OF HEALTH AND
CHICAGO HEART ASSOCIATION
RHEUMATIC FEVER PREVENTION PROGRAM

Culture Kit for Beta Hemolytic Streptococcus

This side up

Keep in refrigerator until used

Do not incubate or expose to heat

Date kit made up . . . . . .

Board of Health, Chicago
Division of Laboratories

BURN SWAB AND TONGUE DEPRESSOR
AFTER USING

THROAT CULTURE FOR BETA HEMOLYTIC STREPTOCOCCI

Patient: ..... Age:... Physician: .....
Physician: ..... Culture date: .....
(Age) (Address)

REASON FOR OBTAINING CULTURE:

- acute respiratory infection
- scarlet fever
- patient on prophylactic penicillin for rheumatic fever
- follow-up after antibiotic treatment for positive culture
- contact of patient with positive culture
- acute nephritis
- acute rheumatic fever
- other .....

ANTIBIOTICS GIVEN BEFORE CULTURE? ..... Yes ..... No.
LABORATORY REPORT: Date received: ..... Date reported: .....
Results: .....
..... Signed: .....

The following instruction sheet was used:

1. Swab both tonsillar areas and the region under the uvula with a continuous, quick sweep of a sterile throat swab. *Do not culture the nose.*
2. With a twirling motion of the swab, inoculate a third of the Petri dish along one side.
3. Replace Petri dish in inner blue wrapper and then insert into outer envelope, being sure to *keep agar side up.*
4. Send to nearest police station before 7 p.m. or to nearest designated Board of Health pickup station.
5. Reports of positive cultures for Beta Streptococci will be phoned to the doctor within 48 hours. Reports of both positive and negative cultures will be mailed to the doctor.
6. For culturing in the doctor's office, inoculate the plate with throat swab as above; streak with a wire loop using sterile technic. Incubate at 37 degree C (98.6 degrees F) for 18 to 24 hours and then read directly for Beta Hemolytic Streptococci.
7. If there are any questions relating to the Throat Culturing Program, call RAndolph 6-8000, extension 436 and ask for Mrs. deCelles.

The ultimate purpose of a school program is ideal. The physicians and families in this area have become very much aware of the importance of throat cultures. One physician is now routinely culturing *all* sore throats. However, with so many avenues for error, such a program for all schools is of dubious value as a community service.

This project was supported by grants from Camden County and The New Jersey State Heart Association. Also, acknowledged with thanks, is the statistical assistance of Miss Majorie T. Bellows, American Heart Association.

403 Cooper Street

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Edward N. Comando, M.D.

Newark

Psychogenic Factors in Infertility*

A girl's best friend is not always her mother. Here are three cases where mothers or mothers-in-law were deleterious factors in pregnancy. This somewhat unusual approach to infertility, opens a new channel to fertility control.

Since the end of World War II, there has been increasing interest in the effects of emotions on obstetrical and gynecologic conditions. Of especial interest in this connection is the problem of infertility. Novak [10] recognizes this, but believes that effective psychotherapy is beyond the scope of the average obstetrician.

With the hope of shedding some light on the subject for the average practitioner, three private patients are discussed below. They illustrate frank emotional problems involved in infertility. While these three couples are all different, they show enough similarity to suggest a pattern. I have attempted some approach to the psychodynamics under competent psychiatric counsel and with the guidance of the literature. The first two patients are secondary fertility problems and they are, perhaps, good candidates for repeated abortion. The third is a primary infertility problem.

CASE ONE

This twenty-four year old school teacher comes from a family of means. She is quiet but smiles easily, giving the impression, however, that she does not "give freely" of herself. Her husband is easy-going and over-protective. They live in her parents' home. The husband is employed in the family business. Whenever questions are to be asked of the physician, or an abnormal circumstance is to be related, it is the husband who makes the call. The mother works in the same family business and gives the impression that she also is overprotective of her daughter.

After one year of conception control following marriage, the patient became pregnant readily. From the fourth to the twentieth week she had continuous spotting, occasionally with clots and cramplike pains. She received the usual treatment and psychologic support. During the thirty-seventh week, she insisted that fetal movement had ceased, but the fetal heart could be heard readily. She was hospitalized the following week for mild pre-eclampsia, at which time no fetal heart was noted in the hospital. After six hours she delivered spontaneously a non-macerated stillborn boy weighing 1600 Grams. Later she received meprobamate for control of a mild postpartum depression.

Four months after the delivery, she returned six weeks pregnant. She informed her parents of her pregnancy a month later when she felt more secure that she would not abort. Soon thereafter she reported low abdominal cramps. She was seen in the office weekly and received a diet rich in vitamins C and K. At twelve weeks she read a magazine article on painless childbirth by Grantley Dick Read. This disturbed her greatly. She started slight vaginal bleeding and experienced uterine cramps. After four days at bedrest and routine measures she started to bleed profusely and was hospitalized. She went into a severe depression. A conservative course was elected with little hope for a successful pregnancy offered. The patient did not eat or sleep for thirty-six hours. Bleeding recurred at the time of a visit by her mother.

About this time the patient asked about the psychologic causes of bleeding and referred to the article in the lay magazine. The possibilities of such influences were discussed with her and this brought out difficulties of living with one's parents. Thereafter she slept well and the following day developed a normal appetite.

*From the Presbyterian Hospital in Newark.

Her condition remained stable for two days, until she passed the conceptus without appreciable pain or blood loss. Curettage was done and she was depressed for about twenty-four hours. During this time the competition between the mother and husband was most evident. Whenever the mother left the patient cheered up. The second day postoperatively, she was discharged.

A month later, the hysterogram showed no filling defects, and there was a competent internal cervical os. Psychiatric counsel gave a hopeless prognosis unless the couple moved into their own quarters. The psychiatrist felt that with such a move and continued ego support, a future pregnancy would stand a far better chance of coming to term normally. The patient in these conferences brought out two significant factors not previously known; that she dreamed before delivery that she would have an extremely small baby and feed it from a miniature bottle; and that she was very fearful of the use of ether anesthesia in connection with a second delivery.

Comment: This patient is immature and this immaturity is encouraged by both her mother and husband. The mother has never allowed her to develop self-reliance, evidenced by insistence on her husband making calls and accompanying her to the office. By acquiescing to such demands he aggravated her inability to assume mature responsibility. She could not imagine herself having a normal-sized baby as evident in dreams, since she never visualized herself as a big enough person. Were she to be large enough to have a normal baby, she would reach her mother's stature; for her, a forbidden state. In consequence, a successful pregnancy would be difficult to attain. If achieved it would be associated with pain as a punishment for the guilt of competing with her mother. This may well account for the panic from reading Read's article and is felt to have influenced in part the subsequent abortion.

CASE TWO

A thirty-six year old hairdresser, five years older than her husband, had been married eight years without children. She and her husband had known each other for five years prior to marriage. She had to "shame him" into marriage after a long engagement; and she was a virgin bride.

She had to leave school at the age of 17 to care for a nephew with rheumatic heart disease, while her sister went to work. Her sisters and mother make her the first recipient of any bad news. She is flighty, talkative, with hands in constant motion. Her insecurity shows in her constant need for reassurances and her capacity to ask questions.

Her husband has an overprotecting mother, a domineering sister, and lives in a dream world. He has a meagre earning capacity supplemented by his wife's efforts.

After eight years of marriage she became pregnant. The pregnancy proceeded normally until the seventeenth week, when she complained of severe abdominal pains for which no adequate explanation was found. At twenty-one weeks the membranes ruptured spontaneously, and four days later she delivered a macerated stillborn fetus.

At this time she mentioned that sexual intercourse was unsatisfactory and asked about her frigidity. She mentioned that both she and her husband were not adequately satisfied, despite premarital experiences of a pleasant nature without actual intercourse. She asked if this could be "psychological" and was sent for psychiatric consultation.

She and her husband received psychotherapy, she for a short period, he for a period of six months. During this period he was able to take a more objective view of his mother and sister, and their marriage outlook improved. At this time, upon his discharge by the psychiatrist, she reported back pregnant.

The pregnancy proceeded normally without nausea or vomiting. At three months, two days prior to Mother's Day (which she always spent with *his* family) she complained of lower abdominal cramps and vaginal bleeding. The bleeding stopped at bed rest and high vitamin diet.

The uterus thereafter showed no increase in size (12 centimeters) and six weeks thereafter, it was back to normal size. The patient went into a moderate depression, stating she expected it all along. When asked why, she stated that she had been having nightmares for several weeks and knew she would lose the baby.

Hysterogram later showed a normal uterus. The patient was advised that in the future continual psychotherapy during pregnancy would be required. It would be also advisable that her husband be under some treatment at the same time.

Comment: This woman, insecure herself, was married to an immature younger man and thereafter supported her ego by dominating him. Controlled by her family, she knew the weight of the responsibilities of motherhood from caring for her nephew. Thus it is not surprising that her system should rebel at the possibility of caring for her own child. Her full capacity was lowered by her family and her husband below the necessary requirements for a happy, emotionally stable and successful pregnancy. The circumstances of the first conception are unknown, but her husband's later psychotherapy and improvement may have lifted some of the load from her shoulders. When the therapist discharged the

husband, her load increased again beyond tolerance.

CASE THREE

A thirty-one year old newspaper woman had been married five years without pregnancy. When she was a child her sister told her that if she were to become pregnant, she would "certainly die because her hips were so narrow." She was her father's pet and was rejected by her mother in favor of a sister. She had many fears and was unable to drive on a highway and tended to be prudish in other respects.

Her husband, a brilliant engineer, was the youngest member of his class. His mother was overprotective and possessive. For two years prior to marriage she was under psychotherapy. During the short engagement period, his mother was sick, but recovered in time for the wedding. Since marriage the couple have been at her beck and call to an extraordinary degree. The husband is overprotective of the wife and insisted on passing personal judgment on the rationale of any treatment suggested. She had a routine infertility workup. The only defect found was a deficient corpus luteum effect on endometrial biopsy. She came to the office at all times accompanied by her husband, his sister or his mother. She has been under psychotherapy for two years.

Comment: This woman has been afraid of pregnancy on two counts: first the immature fear of death implanted by the sister; and the fear of proving the sister wrong by living through a pregnancy. This is complicated by the fact that she must constantly compete with her mother-in-law for the husband's affection. Adding another competitor in the form of a child, gives her further cause to fear for her own security.

DISCUSSION

THE three cases described above are not unique. Anyone actively practicing obstetrics and gynecology has seen similar cases. Despite careful studies, no organic basis has been found for the inability to achieve a normal pregnancy. All cases are failures to date, yet provide material from which we may gather information.

All three of the women have emotional problems requiring aid, and it is reasonable to infer that elimination or sidestepping of the noxious maternal influence would make the job a lot easier. Street [12] once said that, "there are two things man must not criticize if he expects to get along smoothly and these are, mothers and churches." The patient's mother in Case 1, the husband's mother in Case 3 and both mothers in Case 2, are not helping their own chances for grandchildren. Sisters who substitute for mothers in all cases are sometimes to blame.

The practical suggestions made in these cases considered to influence future pregnancies are: *Case* 1: The couple is looking for their own apartment, and the patient has agreed to undergo psychiatric care before and during the next pregnancy. *Case* 2: The husband has agreed to return for psychotherapy with his wife's next pregnancy, and she has agreed to similar care at the same time. *Case* 3: The husband has been advised to return to psychiatric care while the wife continues with her psychotherapy. This should have the effect of blunting the maternal influences in Case 1, sidestepping the bilateral maternal influences in Case 2, and diverting the influence of the husband's mother in Case 3, thus freeing the wife to cope with her own problem.

In these cases, the role of the fathers is unknown. That they do play a part has been shown by Mann,[8] but their role is dependent upon the mother's setting up the prerequisites for that influence on the patient as she presents herself. Many practitioners, recognizing the importance of psychogenic factors, are wary of referring patients or consciously using psychologic technics for fear of driving patients away; or they may fear that they do not have sufficient time. However, this need not be so if the groundwork is laid early. The information gained in these cases has been accumulated over a period of time by observation of the patients and the people surrounding them, by gentle, judicious questioning during the course of the regular routine workup in the office.

The first two couples asked about psychologic causes before the author was ready to refer them to a psychiatrist. The first patient posed the question when she recognized that an acute anxiety state preceded the abortion. The second seemed to sense the relationship between her frigidity and her infertility prob-

lem. With the third patient, possible psychogenic factors were mentioned early in the workup but left for the future. When this woman was ready she proposed the psychiatric consultation herself.

In view of the case presented by Weil and Stewart [13] it seems that "hypothalamic infertility" should probably be added to our list of possible causes of this condition. The role of the hypothalamus has been described in tubal spasm.[6] Weil and Stewart [13] showed a definite alteration of hormonal levels related to emotional problems and threatened abortion. This is probably mediated through the hypothalamic - hypophyseal - neural pathways.[1] Lack of ovulation in the female has for a long time been treated with moderate success by irradiation of the pituitary gland. This has been the most successful means of curing this cause of infertility. The theory is that small doses of x-radiation by hyperemia, and so forth, stimulate the pituitary to function more efficiently and thus initiate ovulation in the ovary.

Often after a year or more anovulatory menses resume. This is attributed to wearing off of the effect. Glandular tissue is more subject to roentgen effect than neural tissue. However, it seems to me more likely, due to the regeneration of neurofibrils than to the "wearing off" of a hyperemic effect. Roentgentherapy, in all other uses, completes its action in about six weeks. It seems to me more logical in anovulatory menses, to infer that the beneficial results are obtained from destruction of the hypothalamic-hypophyseal neurofibrils, freeing the pituitary so that it may function. This would be the same as beneficial results obtained from prefrontal lobotomy, except that here the results are transient and not so destructive.

SUMMARY AND CONCLUSIONS

THREE cases of involuntary infertility have been presented in which psychodynamic factors may play a major role. Certain similarities are found, especially the fact that a mother's influence had a predominantly deleterious effect on a wife's fertility, often through the husband. There probably are more patterns than those posed, but these constitute a good start in recognizing the influences involved in an infertile couple. Psychiatric and/or psychologic consultation should probably be a part of the routine infertility study. However, this should be postponed if the physician senses resistance to the idea by the patient. Then the physician might, to his advantage, look for psychogenic factors when a third party is interposed or interposes himself between the patient and the physician, especially in problems of infertility.

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George T. Whittle, M.D.

Asbury Park

Recent Experiences with Urinary Diversion*

Aggressive surgery with sacrifice of the lower urinary tract may be a life-saving, if bold procedure. Dr. Whittle here reports on 20 such procedures, by a method which he correctly characterizes as: safe, practical, versatile, reliable and effective.

Many patients with pelvic malignancies beyond the stage controllable by the usual more conservative surgical procedures, can be improved by aggressive procedures necessitating sacrifice of the lower urinary tract. Some such patients are denied exenterative surgery because of the bad past experience of patients who became entangled in the vicious cycle of urinary complications in addition to the problems of the exenteration itself.

Past experience with nephrostomies, cutaneous ureterostomies and uretero-sigmoidostomies for urinary diversion, has disclosed serious drawbacks to each of these methods. While many patients do tolerate them, a large proportion have become urologic cripples or have died of urologic disease.

I would like to relate my experience with urinary diversionary procedures done in the past fourteen months, in Monmouth County. Twenty diversionary procedures have been performed. Five were for benign diseases; ten in association with procedures for malignancies of the bladder, prostate and cervix and five for palliation. Ten procedures were accompanied by anterior pelvic exenteration, one by total pelvic exenteration. One palliative procedure had total pelvic exenteration and one a simple cystectomy.

For diversion, 16 isolated ileal loops, one isolated sigmoid loop, two uretero-sigmoidostomies, one "Johnson Procedure," (uretero-sigmoidostomy in isolated loop and anal colostomy), were used.

The curative procedures were done on patients with extensive or highly malignant lesions, confined to the pelvis without gross or frozen section evidence of spread to, or above the lymph nodes at the bifurcation of the aorta. No candidates in this category were refused because of age, weight or coexistent cardiovascular disease.

The series is too small to permit a statistical analysis of its complications. However, of the eighteen patients personally operated upon, ten had smooth postoperative courses, without complications and were discharged on or before the twelfth postoperative day. Eight patients had complications necessitating hospitalization for 12 to 34 days.

One patient who had bilateral uretero-sigmoidostomies, developed obstruction of the lower ureters on the first postoperative day, with bilateral pyelonephritis, necessitating emergency nephrostomies. The left kidney recovered completely. There has been persistent pyelonephritis in the right kidney. The other patient who had uretero-sigmoidostomies, developed bilateral pyelonephritis, four months postoperatively, necessitating ileal conduit diversion.

Complications in patients who had ileal con-

*Read May 20, 1958, Section on Urology, The Medical Society of New Jersey.

duit diversions were: (1) aggravation of decubitus ulcers in a paraplegic, (2) wound disruption on the third postoperative day, necessitating secondary closure, followed by a wound infection in a patient with bronchiectasis, an alcoholic history and an intractable cystitis, (3) severe diarrhea secondary to bowel preparation with neomycin, (4) lower nephron nephrosis and left leg and pelvic thrombo-phlebitis, (5) two patients with extensive carcinoma, who had x-ray therapy (to skin burn), involving the area of implantation of the stoma and the ileum used in the conduit, had difficulty. One of these developed excoriation of the skin around the ileal stoma and the other a delayed urinary leak from her mid-line abdominal wound, three months postoperatively. This persisted intermittently, until her death three months later.

One seventy-six year old woman died on the 34th postoperative day in inanition, secondary to massive liver metastasis and a silent pelvic abscess.

In follow-up, blood urea nitrogens were all within normal limits. All urines studied were free of albumin and all conduit urines showed 5 to 10 white blood cells per high powered field, on uncentrifuged specimens. Review of the pre- and postoperative pyelograms, showed that of thirty-nine kidneys diverted into isolated bowel loops, fourteen have improved, twenty-three were normal and have remained so, one shows minimal hydronephrosis and one is apparently completely obstructed.

Of four kidneys diverted into the sigmoid, one is normal, two are worse on intravenous pyelogram and three have deteriorated functionally.

These procedures, although exacting technical exercises requiring a little more than average postoperative care, are feasible and practical in a well equipped community hospital.

The typical patient who had a urinary diversionary procedure performed, had a 3-hour-and-20-minute operation. He required 700 cubic centimeters of blood and had a 15-day hospital stay, if he had benign disease and a 20-day stay if he had cancer.

The average patient who had a diversion with radical pelvic surgery, had a 4-hour-and-45-minute operation, received two thousand cubic centimeters of blood and stayed in the hospital 16 days.

Recognizing the limited group studied and the short follow-up, the following conclusion can be drawn to date.

SUMMARY

(1) Isolated ileal conduit diversion has been, for us, the most satisfactory method used.

(2) This method is safe, practical, versatile, reliable and effective.

(3) When combined with major pelvic surgery, the operative mortality and complications have been respectably low.

(4) The functional and pyelographic return of even severely obstructed and infected kidneys in all age groups, has been most gratifying.

(5) Most patients are satisfied with the urinary stoma and bag and all have adapted themselves quite well to them.

601 Grand Avenue

Flash Photos

Newborn babies are not harmed by being photographed with a flashgun, reports the *Journal of the American Medical Association.* There is no evidence that flash photos taken during the first few days of life injure an infant's eyes.—*Today's Health,* October, 1958.

William L. Palazzo, M.D.

Teaneck

Experience with Unusual Biliary Tract Disease*

The roentgenogram, in proper hands, is a wonderful tool for the differential diagnosis of gall bladder disease. Dr. Palazzo here presents some unusual disorders in this tract.

Biliary tract disease is among the more common ailments that radiologists are called upon to aid in diagnosis. Radiologic methods at our disposal include the following:

1. Plain films of the abdomen; supine, upright, and lateral recumbent; 2. Oral cholecystography; 3. Oral and intravenous cholangiography and cholecystography; 4. T-tube cholangiography; 5. Trans-hepatic cholangiography; 6. Portal venography; 7. Barium contrast studies of the intestinal tract; 8. Simultaneous roentgen examination of the urinary and biliary tracts;[1] 9. Contrast enhancement with television technics.[2]

Garfinkel and Furst [1] recently demonstrated the biliary tract and kidneys simultaneously by the use of Duografin® intravenously. Gershon-Cohen [2] has recently shown the presence of an adenoma of the gall bladder with beautiful color enhancement using television technics.

The material presented represents the highlights of one man's experience with biliary tract problems over the last ten years. It is presented only from the radiologic point of view. Many medical and surgical problems have developed from the cases studied. However, surgical technics, problems, and decisions will be commented on in passing.

Most common forms of biliary tract disease are associated with calculi. Calculi may be opaque, non-opaque, large, small, or in combination. They may be solitary, few, or fill the gall bladder. They may obstruct the cystic or common bile ducts, and may occur within the intrahepatic ductal system.

Congenital abnormalities of the gall bladder include: septate gall bladder, phrygian cap deformities, double gall bladder, dependent gall bladder, intrahepatic gall bladder, atrophic gall bladder and left sided gall bladder in *situs inversus*. A choledochus cyst is an occasional finding. Polyps of the gall bladder and bile ducts are not uncommonly seen at surgery or autopsy, and figures vary from 2 to 8 per cent. They are not too often visualized radiographically. Malignant tumors may be infiltrating or polypoid, and occur in the gall bladder often associated with stones. Their presence in the bile ducts is not uncommon.

Infection in the gall bladder may be chronic or acute, and may occur with or without calculi. A chronically inflamed gall bladder may contain milk of calcium bile. Calcification may occur in the wall of a gall bladder that has been the seat of chronic long-standing inflammation.

One rare type of cholecystitis is characterized by the formation of many small diverticulae in the wall of the gall bladder (Rokitansky-Aschoff sinuses). Roentgen visualiza-

*Read May 20, 1958 at the Annual Meeting of The Medical Society of New Jersey.

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tion of this condition was first reported by March[3] in 1948. Since then, additional cases have been cited by Culver, Berens and Bean;[4] Moore;[5] Friedman and Skornick;[6] Pagan-Carlo[7] and others. Superficial perusal of the literature indicates about 30 reported cases. This paper adds two more cases. Pagan-Carlo[7] confirms the presence of stenosis in the neck of the gall bladder. The two illustrated cases here show stenosis in the midportion of the gall bladder. One of these contains three non-opaque calculi. The formation of Rokitansky-Aschoff sinuses is the result of chronic infection associated with increased intra-luminal pressure, and requires surgical removal.

Another rare type of gall bladder disease is characterized by the presence of gas within the gall bladder. In some cases it has been thought to be the result of infection with clostridium Welchii organisms. Heifetz[9] found a total of 52, including his own. He and La-Cour[8] describe the presence of gas and fluid levels in the upright positions. Some have been reported without fluid. The case of acute pneumocholecystitis presented here, showed a gall bladder distended with gas, and without fluid in the upright position. No air was found in the ductal system. It is presumed that there was associated stenosis or obstruction in the cystic duct. This patient was treated conservatively, for two months; and then the gall bladder was removed. In general, surgical opinion favors conservative therapy, because of the danger of uncontrollable gas bacillus infection, if this kind of patient is operated on in the acute stage. When the acute infection has subsided, cholecystectomy is recommended.

The following case illustrates what probably represents congenital dilatation of the common bile duct, possibly with stenosis of the lower end. The flat film showed a number of faintly opaque calculi in the right upper quadrant of the abdomen. Following oral Telepaque®, a shadow resembling the gall bladder became faintly opacified, and the group of calculi appeared to lie medial to it. At operation, the gall bladder showed chronic inflammation. Large calculi were found in an enormously dilated common duct, with several in the hepatic ducts. The gall bladder was removed, the ducts cleaned out, and a T-tube was placed for drainage. This patient had not been jaundiced. Postoperative cholangiography illustrates the dilated common and hepatic ducts.

Fistulas between the gall bladder and gastrointestinal tract have been described in recent literature. Gall stone ileus is an acute surgical emergency, and occurs when a gall stone, which has passed through the wall of the gall bladder into the small intestine, becomes impacted in the ileum, usually at the ileocecal valve. Braxton and Jacobson[10] mention two previous cases of intragastric gall stone, and add one of their own. Figiel and Figiel[11] describe four cases of gall stone in the duodenal bulb with obstruction. Carlson, Gates and Novacovich,[12] review 13 cases of spontaneous fistula between the gall bladder and the gastrointestinal tract; ten into the duodenum, two into the stomach, and one into the colon. DeFeo and Meigher[13] found 31 recorded cases of cholecystoenteric fistula, and added two cases of gall stones impacted in the stomach, and one impacted in the duodenal bulb.

The case presented here demonstrates a fistula which occurred between the gall bladder and the proximal transverse colon. Roentgenographic examination revealed some air in the biliary tree; and subsequently barium enema produced regurgitation of barium into the gall bladder, hepatic ducts, and common duct. The common duct was dilated, and a large calculus was found impacted in its lower end. This was

3. March, H. C.: Am. J. Roentgenology, 59:197 (1948).

4. Culver, G. J., Berens, D. L. and Bean, B. C.: Am. J. Roentgenology, 77:47 (1957).

5. Moore, R. D.: Am. J. Roentgenology, 75:360 (1956).

6. Friedman, E. and Skornick, A.: New Eng. J. Med., 225:940 (1956).

7. Pagan-Carlo, J. and Gentner, G. A.: Am. J. Roentgenology, 79:872 (1958).

8. La Cour, E. G. and O'Neil, L. J.: Surgery, 39:813 (1956).

9. Heifetz, Carl J.: Am. J. Surgery, 91:449 (1956).

10. Braxton, M. and Jacobson, G.: Am. J. Roentgenology, 78:631 (1957).

11. Figiel, L. S. and Figiel, S. J.: Am. J. Roentgenology, 76:24 (1956).

12. Carlson, E., Gates, C. Y. and Novacovich, G.: Surg. Gynec. & Obstet., 101:321 (1955).

13. DeFeo, E. and Meigher, S.: Am. J. Roentgenology, 77:40 (1957).

treated by taking down the fistula, removing the gall bladder, exploring and cleaning out the common duct, and drainage with a T-tube.

SUMMARY

Numerous instances of unusual biliary tract disease are presented. These include polyp of the gall bladder; calcified wall of gall bladder; milk of calcium bile; left sided gall bladder; demonstration of Rokitansky-Aschoff sinuses in two cases, one with gall stones; pneumo-cholecystitis; choledochus cyst with calculi; cholecysto-colic fistula. The roentgenologic characteristics are discussed, and management of the cases are briefly reviewed.

757 Teaneck Road

Diphtheria is Still Here

A virulent attack of diphtheria felled eleven members of a family in Monmouth County last month. Commenting on the case, Dr. Geoffrey W. Esty, District State Health Officer, writes:

1. Diphtheria is a constant threat. Do not be complacent about it.

2. It is helpful to the control of disease if children are required to be immunized against certain diseases as a prerequisite to admission to school. (The Medical Society of New Jersey recently urged county medical societies to encourage immunization of school children against diphtheria and poliomyelitis.)

3. School admission requirements must be enforced if they are to be effective.

4. The State Department of Health can help in the control of such situations when the appropriate District office is promptly advised. In this instance, the Department helped find a private physician who agreed to treat the family without charge. Through its laboratory, the Department established the strain of diphtheria, its virulence, the antibiotic which is most effective in treating it, and helped establish that no persons outside the family had been infected.

But!*

Some people take pride in prejudice; they are not ashamed. And yet prejudice — the slimy feeling of false superiority—is, together with nationalized greed, the root of war. Prejudice is a weapon to destroy a people and a nation. The extermination of prejudice is not accomplished by wars but by ordinary men, women and children, through their attitudes toward one another.

Mankind's worst enemies do not fight openly, stating: "I hate this . . . or that. Take it or leave it." Such are easier to meet in combat. They operate as underground murmurs: the stabbing word, so casual; the undermining phrase, spoken in good humor. Usually they declare their way by saying, "You understand I haven't a shred of prejudice personally . . . *but* . . ."

Never let it pass. Pin it down, drag it out. Ask: Why? Ask: When and where? Present your rebuttal and in no spirit of apology.

Propaganda is not only for State Departments. It is for everybody!

*By Faith Baldwin. This is published in the interest of Brotherhood Week.

Thomas K. Rathmell, M.D.

Thomas V. Egan, B.S., M.T. (ASCP)

Jorge Mora, M.D.

Trenton

Electrophoretic Mobility of Hemoglobins*

In diagnostic hematology, electrophoretic studies of hemoglobin have proved to be increasingly valuable. This paper describes the technics and methods.

The material presented below is compiled solely for the purpose of demonstrating fundamentals and reliable technics which have been proved by time and personal experience in our laboratory. We hope to stimulate others to adopt these methods and thereby make them more readily available to the medical profession of New Jersey.

"It is characteristic of science and progress that they continually open new fields to our vision." This statement of Pasteur will be recognized by those who examine the cover of the *Journal of Bacteriology*. It expresses the progress made by modern developments in hemoglobin study by means of electrophoresis. Electrophoretic patterns of the hemoglobins have been determined over a sufficient length of time, and the technics have become so standardized that this method of study should now be available to all physicians interested in the study of a patient with anemia. When the New Jersey Society of Clinical Pathologists and Medical Technologists initiated their program of scientific seminars which are now held annually, Dr. Murray Shulman was one of the early demonstrators of the technics of hemoglobin electrophoresis.

Abnormal hemoglobins occur as a result of genetic factors. These abnormalities affect the behavior of hemoglobin in erythrocytes and are responsible for disturbances such as those seen in sickle cell disease. The abnormal hemoglobins differ in their electrophoretic mobilities from the normal adult form of hemoglobin. It is this simple fact which enables their separation, by means of electrophoresis, and facilitates the study of any patient with anemia.

Electrophoretic studies will enable one rapidly to segregate four forms of sicklemia, namely:

1. Sickle cell anemia.
2. Sickling trait.
3. Sickle cell hemoglobin C. Disease.
4. Sickle cell thalassemia (micro-drepanocytosis). This condition is acquired by the transmission of the sickling gene from one parent and the gene for thalassemia from the other parent.

Hemoglobins migrate from the cathode or negative pole, towards the anode, or positive pole.

The procedure and equipment for the preparation of electrophoretic material is as follows:

*Read May 20, 1958 at the Annual Meeting of The Medical Society of New Jersey. This work is from the Department of Pathology, Mercer Hospital, Trenton.

EQUIPMENT AND REAGENTS

1. Electrophoresis cell and D.C. power supply.

A constant voltage regulator was assembled, Model PS3, secured from the Heath Co., Benton Harbor, Michigan, and a suitable plastic electrophoretic cell of rectangular shape was constructed by Mr. Egan. Whatman filter paper No. 3 was utilized between glass plates.

We adopted a buffer recommended by Motulsky, Paul and Durrum,[1] the composition of which is: Sodium barbital 20.6 Grams per liter; diethyl barbituric acid 3.68 Grams per liter. This is to be diluted 1:1 with water, prior to use.

Micropipettes No. 4937-W-13 were obtained from the Arthur H. Thomas Co., Philadelphia. These facilitate measurements of 1/1000 milliliter (one lambda).

PREPARATION OF HEMOLYSATE

1. Collect 8 cubic centimeters of oxalated blood.
2. Centrifuge and remove plasma.
3. Wash red blood cells three times with physiologic saline.
4. After last wash, all the saline is removed; an equal volume of water and half volume of toluene is added.
5. This mixture is shaken for 5 minutes. Centrifuge for 20 minutes at 2000 revolutions per minute.
6. The two upper layers are discarded and the lower layer is filtered. (This filtered portion is the hemolysate.)

PREPARATION OF THE ELECTROPHORETIC SAMPLE

1. A piece of Whatman No. 3 filter paper is prepared by drawing a line down the center and marking spots for the samples. (*A normal hemoglobin and a positive sickle hemoglobin are run in each set.*)
2. The paper is wetted with the buffer and blotted dry, and placed on the glass plate.
3. Three lambda of the hemolysate are applied.
4. The upper plate is clamped in place. This is placed in the cell, with the ends of the paper in the buffer chambers.
5. The current is applied for 18 hours at 110 volts.
6. The paper is removed and dried in the oven for 15 minutes.

ALKALI DENATURATION REAGENTS

1. Exactly N/12 Sodium Hydrate (this solution is to be kept in the refrigerator in paraffin-lined bottles).
2. Precipitant—800 milliliters of 50 per cent saturated ammonium sulphate plus 2 milliliters of 10-normal hydrochloric acid.

ALKALI DENATURATION TECHNIC

IT IS important to realize that fetal hemoglobin will migrate approximately the same distance as adult hemoglobin; consequently, to distinguish between adult and fetal hemoglobin, one must utilize chemical methods developed by Singer, Chernoff and Singer.[2]

This is accomplished by adding 0.1 milliliter of the hemoglobin hemolysate to 1.6 milliliters of the alkaline reagent, after it has been placed in a water-bath at 20 degrees centigrade for several minutes. The pipette from which the 0.1 milliliter of the hemoglobin hemolysate is added is rinsed six times and the test tube gently shaken for ten seconds. A stop-watch is started at the moment the hemoglobin is introduced into the denaturing medium. After exactly one minute, 3.4 milliliters of the precipitating solution are added, the test tube inverted six times. The mixture is

1. Motulsky, A. G., Paul, M. H. and Durrum, E. L.: Paper Electrophoresis of Abnormal Hemoglobins. *Blood*, 9:897 (1954).

2. Singer, K., Chernoff, A. I. and Singer, L.: Studies on Abnormal Hemoglobins. *Blood*, 6:413 (1951).

TYPES, RELATIVE MOBILITY AND OCCURENCE OF HEMOGLOBINS

Hemoglobin	Designation	Relative Mobility	Occurrence
Normal adult	A	Migrates greatest distance	Normal adult
Fetal	F	Slightly less than A	Fetus, newborn, infancy during early months; thalassemia, sickle-cell disease; sickle-cell Hgb. D disease.
Sickle cell	S	About ½ that of A	Sickle-cell anemia; sickle-cell trait. In combination with Hgb. C and Hgb. D, and in thalassemia.
C	C	About ½ that of S	Hgb. C disease; Hgb. C trait; sickle-cell Hgb. C disease.
D	D	Same as S	Hgb. D trait; Hgb. D, Hgb. S disease.
E	E	Between A and S	With F in a case of atypical anemia.

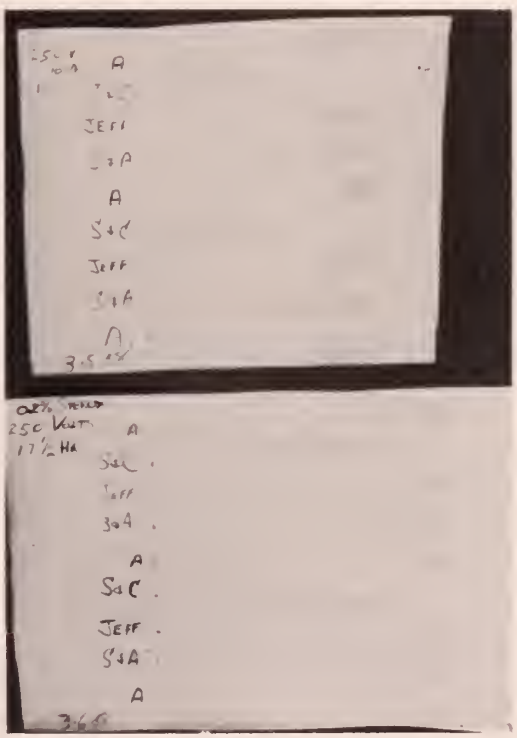
immediately filtered through a double layer of filter paper.

With normal adult hemoglobin, the filtrate is found to be colorless, while in the presence of resistant compounds (only fetal hemoglobin is resistant), a faintly brown to deep red color may be seen. For qualitative determinations, it is only necessary to watch for the appearance of this color immediately after the process is finished.

We are quoting the following statements directly from the work of Motulsky, Paul and Durrum.[1] They should be constantly in mind when attempting electrophoretic studies.

1. "Hemoglobin D does not give a positive sickling test with reducing agents."
2. "Fetal hemoglobin cannot be separated from adult hemoglobin, and for this reason, the alkali denaturation test was always used for the determination of fetal hemoglobin."
3. "Paper electrophoresis is a better differential diagnostic tool than the alkali denaturation test, since 3 per cent of patients with sickle cell anemia have a normal alkali denaturation test."
4. "Sickle cell hemoglobin C disease was found to be a milder anemia with fewer symptoms than classical sickle cell anemia. Electrophoresis is essential for diagnosis of this type of sicklemia."
5. "Hemoglobin C so far has not been encountered in white people."
6. "Heterozygous hemoglobin C carriers showed no evidence of hematologic disease, although many target cells and increased osmotic resistance were always seen."

Recent experimentation with sheets of filter paper of greater width have been tried, in the hope that a large number of hemoglobin specimens could be successfully studied by electrophoresis at one time. With simple electrodes, it became evident that at 340 volts, for a period



Illustrating, in the lower photograph, the enhanced migratory pattern of hemoglobins obtained by the addition of 0.2% Sterox† to the buffer solution. The cases represented illustrate an example of the electrophoretic patterns of adult hemoglobin (A), hemoglobin C combined with S hemoglobin (S & C), adult hemoglobin from a case of Mediterranean anemia (Jeff) and a case of Sickling trait (S & A).

†We used a poly-oxy-ethylene ether brand-named as Sterox® by the Monsato Chemical Company of St. Louis.

of six hours, there was some electrophoretic lag in the migration of specimens at either edge of the paper. Consequently, anyone contemplating this technical modification is advised to limit the width of the filter paper. Other trials with filter paper having a width of 12 centimeters and using 150 volts, for a period of 18 hours, showed that good migration was obtained with the hemoglobin samples throughout the entire width of the filter paper.

We also experimented with a nonionic detergent† (Sterox®), as recommended by Downs, Geller, Lunan and Mann,[3] for electrophoretic separation of serum proteins and find that it works admirably for separation of hemoglobins. We recommend its addition in a 0.2 per cent concentration to the buffer solution.

3. Downs, James J., *et al.*: Nonionic Detergent in Paper Electrophoresis of Serum Proteins. Journal of Laboratory and Clinical Medicine, 51:317 (1958).

SUMMARY

1. Technics and methods for hemoglobin electrophoresis which have been found reliable in our laboratory are presented.

2. Paper electrophoretic studies on all cases of anemia enable the physician to acquire a better concept of their etiology.

3. The finding of sickling morphology of red blood cells in any blood smear demands that electrophoretic studies be instituted, in conjunction with chemical determinations for fetal hemoglobin, if the doctor wishes a complete knowledge of the patient's hemoglobin pattern and a better comprehension of his anemia.

446 Bellevue Avenue

Night Feeding in Infancy

Birth weight is the factor that determines how long an infant must be fed at night, reports the British *Lancet* 1:877 (1958). A study in Middlesex where demand feeding is encouraged showed that of 55 babies whose weight was less than 6.5 pounds at birth, only 9 per cent had never had a night feeding, compared with 52 per cent of the 63 who weighed more than 8 pounds at birth. These differences disappeared by the age of 3 months —91 per cent of the smaller babies and 89 per cent of the heavier babies had ceased their night feedings. — *Foreign Letters*, J.A.M.A., June 21, 1958.

It Was Always Thus

Confronted with the problem of juvenile delinquency, one writer summed up the situation in these blunt words: "Our youth now love luxury. They have bad manners, contempt for authority, disrespect for older people. Children nowadays are tyrants. They no longer rise when their elders enter the room. They contradict their parents, chatter before company, gobble their food and tyrannize their teachers." Timely as they may seem, these were the words of Socrates, written in the fifth century before Christ.—*Journal of the American Medical Women's Association*, June, 1958.

Bertram M. Kummel, M.D.

Morristown

Common Gait Disturbances in Children*

Mothers and fathers are understandably worried when a child exhibits a gait abnormality. This is such a conspicuous disability, and it so often leads to teasing and embarrassment. Here Dr. Kummel offers a ready reference roster of the leading gait abnormalities.

When there is a complaint concerning the way a child walks, the ordinary history and physical examination supplemented by x-ray and occasional laboratory studies, will usually solve the problem. It does not hurt to watch the stripped child circumnavigate the office. However, careful observation of the individual bones and joints, is generally far more revealing.

PIGEON-TOED CHILDREN

The parent may complain that the child has "toed-in" ever since he began to walk. Generally, this child began to walk at the usual age and does not have any pain. There are three common regions in which deformity can cause such an appearance: femoral, tibial or metatarsal.

1. *Femoral.* This is usually called "excessive femoral anteversion." Observation of the standing child who has been stripped below the waist will sometimes reveal that he does stand with the toes pointing toward each other. Moreover, it can be seen that the patellae also point toward each other. More often the child stands with the feet straight because of the mother's strict and repeated injunctions that he do so.

When the child is placed on the table supine and the hips are internally rotated in the extended position, there is often more than 90 degrees of such motion. In some of these children it appears that the knees can almost face backwards. On the other hand, when the hips are externally rotated, there is usually only 10 to 20 degrees of movement beyond neutral. In my experience this condition is usually bilateral and unassociated with either of the other two lesions which cause toeing-in.

2. *Tibial Torsion.* Far more common is internal tibial torsion. It is recognized by the fact that when the patella faces anteriorly, the plane of the ankle joint faces inward. This is more easily recognized clinically than radiographically. Tibial torsion and varus of the forefoot often coexist. When one is found, the other should be suspected.

3. *Metatarsus Varus.* This may exist alone, as part of a true club foot, or with tibial torsion. All three may occur together. Frequently, some doubt arises after birth about the existence of metatarsus varus because the forefoot appears to be turned in. The diagnosis depends not so much upon this appearance as upon whether the forefoot can be ab-

*Read before the Section on Orthopedic Surgery, Annual Meeting of The Medical Society of New Jersey, May 21, 1958.

ducted on the hind foot. If the forefoot can easily be pushed laterally on the hind foot, there is no contracture and, therefore, no metatarsus varus.

The diagnosis of club foot rarely occasions difficulty.

BOWED LEGS

Frequently, a mother will complain that the child's legs are "bowed" and have been since birth. Often, she has been told that time will correct the trouble. When a couple of years have gone by and the child still looks like a miniature cowboy, mother becomes a little frantic. Correct evaluation and treatment become imperative.

First, such causes as rickets, scurvy, and other generalized diseases must be ruled out. In the large remaining group, clinical and radiologic examinations demonstrate that the bowing is almost wholly tibial. Further observation reveals a definite element of tibial torsion in a large proportion of these cases. Recognition of the torsion factor is important in that response to treatment appears to be more rapid with a better end result when such therapy specifically corrects both factors.

In a few cases of bowing of the legs, x-rays will show unequal growth of the two sides of the upper tibial epiphysis. Often there is premature closure of the medial half of this growth plate. This is sometimes called Blount's Disease. In these cases the varus deformity may be severe and treatment will be unsatisfactory. The medial collateral and cruciate ligaments become elongated and incompetent, and the knees subluxate in the erect position.

"SHORT LEG" DUE TO HIP DISEASE

A not infrequent complaint by a parent is that one of the child's legs is short. There may be no history of acquired disease or pain. Deformities below the knee are fairly obvious but a fat, pudgy thigh can cover up a severe lesion. Comparative measurement of the lengths of the thighs is difficult unless the child is placed in the supine position with the hips and knees flexed and the soles of the feet flat on the table. Comparison of the height of the patellae gives a fairly accurate observation.

When it is determined that a femur is short, congenital dysplasia of the hip comes to mind first. Further examination is done in order to detect telescoping, Hart's sign of limited abduction, and Ortolani's "click sign." None of these may be demonstrated when dysplasia exists. Indeed, the shortening may also be absent. The lesson is that children's hips should be x-rayed whenever there is any doubt. Beware of bilateral hip dysplasia where comparison of the two sides is not valid.

A rarer congenital hip condition is the "short femur." Congenital coxa vara which is really a pseudarthrosis of the femoral neck requires early operative intervention if a good result is to be obtained. It is not generally recognized that cases diagnosed on x-ray as congenital absence of the upper end of the femur are in reality instances of coxa vara. Here the upper end of the femur remains cartilaginous and fails to cast an identifying shadow on the radiograph. Early surgery is imperative.

ACQUIRED HIP DISEASE

Thus far only painless conditions which have been present since the age when walking begins, have been considered. Now let us consider the problem of the previously normal child who develops a painful limp. First, there is the group with pain in the hip. Limitation of motion, including a flexion contracture and a positive Trendelenburg sign, are also present. Initially, pyogenic and tuberculous infections must be ruled out and also such systemic diseases as poliomyelitis.

In the ages from three to ten, x-rays may reveal Legg-Perthes Disease in one of the early stages. In this same age group, an acute disease of the hip joint may occur which is called "transient synovitis." It is a diagnosis made by exclusion of the other lesions of the

hip and confirmed by relatively rapid subsidence of the symptoms and signs, no residua being noted afterward. Usually, the same acute pain in the groin and limp occur accompanied by a fever, high white cell count, and elevated sedimentation rate. Aspiration of the joint is frequently necessary to differentiate this disease from a pyogenic arthritis. X-rays are consistently negative.

In the next age group ranging from 10 to 16, the practitioner must consider a slipped epiphysis when presented with an "acute hip." The signs and symptoms may be minor and a high index of suspicion is necessary, particularly if the early, minimal slips are to be picked up. The classic signs of an external rotation deformity, shortening, and a positive Trendelenburg are not always present.

KNEE PAIN

FREQUENTLY, in children or adults, a hip lesion may present itself as a pain localized to the knee. Always examine the hip in such cases. X-ray the hip as well as the knee if the site of the disease is in doubt.

Every doctor knows what Osgood-Schlatter's Disease is *clinically* and that is the way to make the diagnosis. The so-called typical radiologic appearance is just as likely to be present on the painless side or in the knee of the next child who is asymptomatic.

Osteochondritis dissecans is not unusual in the latter part of childhood. The symptoms and signs are similar to other internal derangements of the knee, including occasional locking. Beware of the presence of an accessory center of ossification which resembles this lesion on the x-ray. Such centers are usually located away from the median plane of the joint and are almost always bilateral. X-ray both knees if there is any question and include tunnel views.

FOOT PAIN

ANKLE lesions are rarely a problem in differential diagnosis. Osteochondritis and other traumatic lesions comprise most of the cases.

Painful feet in childhood are unusual, even in the presence of severe disease. Whenever a child has such a complaint, it is wise to heed it, because a definite organic cause can often be found. As an illustration a case is presented where a child suffered an injury to the foot. Good x-rays in two planes were repeatedly negative; yet, the child complained of pain in the heel and refused to walk. Axial views of the calcaneus revealed a fracture with slight displacement.

Osteochondritis dissecans may occur at many sites in the foot. The most frequent is the navicular. Any of these necroses may cause a painful limp.

Congenital anomalies may be the source of pain and an abnormal gait especially in the early teens. Ordinary flaccid flat feet may fatigue at this age but pain arrives later. Prominent accessory naviculars and early bunions due to splay feet become tender as a result of pressure by the shoes. Plantar-flexed tali, naviculo-cuneiform sags, and congenital synostoses cause symptoms early. All these lesions are best demonstrated by x-rays of the foot in various planes while weight is being borne.

OTHER CONDITIONS

SCOLIOSIS may cause a hip to be prominent or a leg to appear shorter. The neuromuscular diseases sometimes enter into the differential diagnosis. Cerebral palsy, despite all the publicity in recent years, is still missed too often.

34 Elm Street

Louis J. Levinson, M.D.

Newark

Treatment of Hyperthyroidism with Radioactive Iodine*

Radioactive iodine brought about a satisfactory remission in 90 per cent of toxic diffuse goiter patients. Only 6 per cent suffered hypothyroidism as a side-effect. Radioactive iodine is also shown to be useful in patients with thyroidogenic heart disease.

The Atomic Energy Commission first released radioactive iodine (I 131) for extensive clinical use in 1946. Since then thousands of patients have received radioactive iodine therapy for hyperthyroidism. Radioiodine (I 131) has a radioactive half life of 8.1 days. On undergoing radioactive decay it emits both beta and gamma radiation. About 90 per cent of this radiation is in the form of beta rays. These beta rays have a short range in tissue, of approximately 2 millimeters. The effective radiation is therefore localized in the thyroid gland. As with all types of ionizing radiation the possibility of carcinogenesis was seriously considered. During the past 12 years of intensive clinical use *there have been no reports of carcinoma of the thyroid gland developing in humans following radioactive iodine* therapy for hyperthyroidism. The resulting changes in the thyroid gland caused by small doses of radioiodine may be so slight that they are difficult to evaluate [1] on the basis of histologic examination.[2] However, as the dose of radioiodine increases atrophy of thyroid follicles and resulting fibrosis have been noted. When really massive doses are used in the therapy of thyroid gland cancer,[3] actual ablation of the thyroid gland and replacement by avascular fibrous tissue results.[4]

CLINICAL MATERIAL

This report is a review of the findings and results in 300 patients referred to the Radioisotope Department of the Newark Beth Israel Hospital for the treatment of hyperthyroidism between 1951 and 1956. There were only 70 males in this series, a sex ratio of one male to four and a half females. The age distribution follows:

*This work is from the radioisotope department of the Newark Beth Israel Hospital. This paper was read May 20, 1958 before the radiology section at the Annual Meeting of The Medical Society of New Jersey.

1. Daily, M. E., Lindsay, S. and Miller, E. R.: Histologic Lesions in the Thyroid Glands of Patients Receiving Radioiodine for Hyperthyroidism. J. Clin. Endocrinol., 13:1513 (1953).

2. Dobyns, B. M., Vickery, A. L., Maloof, F. and Chapman, E. M.: Effects of Therapeutic Doses of Radioactive Iodine on the Thyroid. J. Clin. Endocrinol., 13:548 (1953).

3. Seidlin, S. M., Rossman, I., Oshry, E. and Siegel, E.: Radioiodine Therapy of Metastases from Carcinoma of the Thyroid. J. Clin. Endocrinol., 9:1122 (1949).

4. Levinson, L. J., Siegel, E., Kannerstein, M., Tabowitz, D. and Furst, N. J.: Radioiodine in the Diagnosis and Treatment of Carcinoma of the Thyroid Gland. J. Newark Beth Israel Hosp., 6:209 (1955).

Age	Cases
10-19	1
20-29	45
30-39	96
40-49	122
50-59	63
60-69	50
70-79	13

Two hundred and seventy patients in this series had toxic diffuse goiter. Sixty-nine had recurrent postsurgical hyperthyroidism and forty-four had toxic nodular goiter.

Seventy-seven or 20 per cent of this series suffered from serious cardiac complications. Patients with toxic nodular goiter were as a rule accepted for radioactive iodine therapy when they were judged to be poor surgical risks.

METHODS

The initial therapeutic dose was determined[5] by estimating the weight of the thyroid gland[6] and the average effective half life[7] of the I 131 within the thyroid gland.[8] Estimation of the weight of the thyroid gland was based on palpation and comparison of the established weight in normal individuals.

Average dose was theoretically estimated as 7,000 r.e.p. to the thyroid gland. Following the initial therapeutic dose the patient was then observed two to three months before additional administration of I 131 was considered. Lugol's solution was prescribed following I 131 therapy only in patients who had severe cardiac or psychotic manifestations. These patients received 5 drops of Lugol's solution twice daily, starting on the fourth day after the administration of the radioactive iodine, for a period of two to four weeks.

Fifty per cent of the patients with diffuse toxic goiter required one dose of I 131 before a clinical remission was obtained. Another 25 per cent required two doses and the remainder received three to eight doses before a satisfactory clinical result was noted.

In the toxic diffuse group, the total therapeutic dose of I 131 varied from a minimum of two millicuries to a maximum of thirty-five millicuries. Most of these patients, however, received total doses that were between three and five millicuries. In the toxic nodular goiters, multiple doses were necessary in over 70 per cent of these patients and the total dose was much greater than in the toxic diffuse goiter patients. Total doses of twenty millicuries or more were administered to about one-third of those treated for toxic nodular goiter.

Results of treatment are displayed in the table. Each patient was observed for at least one year after administration of the first dose of I 131. As a rule, in patients with toxic diffuse goiter, the thyroid enlargement disappeared when a good clinical result was obtained. However, in toxic nodular goiters, a remission or improvement of hyperthyroid symptoms was frequently obtained with persistence of thyroid enlargement. Exophthalmos was noted in 52 per cent of patients with toxic diffuse goiter. There was satisfactory recession of the exophthalmos in 40 per cent of these. One showed marked aggravation of this condition. This complication occurred in a forty-five year-old female who was treated and cured of hyperthyroidism in 1954.

5. Quimby, E. H.: Brookhaven Symposium on Radioiodine. Page 43 (July 1948).

6. Werner, S. C., Quimby, E. H. and Schmidt, C.: Radioactive Iodine in Hyperthyrodism. Am. J. Med., 7:731 (1949).

7. Feitelberg, S., Kaunitz, P. S., Silver, S., Simon, N., Wasserman, L. R. and Yohalem, S. R.: Hyperthyroidism; Treatment with Radioactive Iodine. Arch. Int. Med., 85:471 (1950).

8. Miller, E. R.: Experience at the University of California with the Treatment of Patients with Hyperthyroidism by I 131 UCRL-1948. U. S. Atomic Energy Commission. Technical Information Service, Oak Ridge, Tennessee, April 1951.

RESULTS OF TREATMENT

	No. of Patients	Cured	Improved	Unimproved or Recurrent	Lost to Follow-up	Died Following Therapy
Toxic diffuse goiter	277	247	14	2	10	4
Toxic nodular goiter	44	32	7	1	1	3
Recurrent postsurgical hyperthyroidism	69	58	5	1	2	3

At the onset of therapy a moderate exophthalmos was noted. Two years later she developed a severe unilateral exophthalmos without evidence of recurrent hyperthyroidism.

Clinical symptoms of hypothyroidism developed in forty-one individuals. Symptoms of hypothyroidism generally appeared from 2 to 4 months following therapy. Most of those developing frank hypothyroidism received only one therapeutic dose. More than half of those who developed hypothyroidism received 8,000 r.e.p. or less. In sixteen of the hypothyroid patients, euthyroid function was established spontaneously several months after the onset of hypothyroidism.

SIX per cent of the 390 individuals treated developed persistent hypothyroidism. In spite of the much larger doses of I 131 administered to the toxic nodular goiters *not a single patient of the forty-four developed hypothyroidism.* The symptoms of hypothyroidism were readily controlled in most patients developing this complication, by the daily oral administration of moderate doses of desiccated thyroid extract. In the toxic diffuse goiter group, 190 patients were studied with twenty-four hour uptake determinations of tracer doses of I 131 prior to the administration of the initial therapeutic dose and before each subsequent dose. A final uptake study was also done on completion of the therapy when a good clinical response was evident. Twelve per cent of these individuals demonstrated a residual elevation of the twenty-four hour uptake in spite of the good clinical response.

With the establishment of euthyroid function the 77 patients with severe cardiac complaints, with but few exceptions, showed marked improvement in their cardiac status. In forty-one patients with auricular fibrillation, normal rhythm was restored in thirty-five. In six cases arrhythmia persisted. Of the 32 patients with congestive heart failure, 24 were entirely compensated following I 131 therapy, five died, and one is still in failure. There were ten deaths in this series. Three died of diseases unrelated to their hyperthyroidism. The remainder of the deaths occurred in patients with a prolonged history of hyperthyroidism, or recurrent postsurgical hyperthyroidism. These patients had severe cardiac damage at the onset of therapy. Actual mortality rate related to hyperthyroidism was under 2 per cent. Postmortem examinations were done on two of these patients and thyroid gland tissue was thus obtained for histologic examinations. Postmortem findings in the thyroid gland in one of these cases were:

This was a 50 year-old woman who was a thyrocardiac with three postsurgical recurrences of her hyperthyroidism. She died seven weeks after the administration of 3.8 millicuries of I 131, estimated to deliver 11,000 r.e.p. The thyroid gland showed no fibrosis or other changes which could be attributed to the radiation effects.

Another case of analytical interest was one in which a subtotal thyroidectomy was done following radioactive iodine therapy. This 63 year-old woman was classified as a therapeutic failure. Ten months following two doses of I 131, totalling fourteen millicuries, histologic examination of the thyroid gland after thyroidectomy, showed marked cystic colloid changes. There was no evidence of hyperplasia or excessive fibrosis.

DEATHS FOLLOWING I 131 THERAPY

Age	Sex	Cause of Death
58	M	Suicide
50	F	Congestive Heart Failure
67	F	Congestive Heart Failure
66	F	Congestive Heart Failure
55	M	Coronary Occlusion
44	F	Congestive Heart Failure
61	F	Bronchopneumonia
47	F	Carcinoma of Endometrium
55	F	Congestive Heart Failure
65	F	Auricular Fibrillation Parkinson's Disease

DISCUSSION

THE estimation of the required dosage of I 131 in the treatment of hyperthyroidism is at best an approximation. Since all calculations as now used must take into consideration the weight of the thyroid gland, this factor in itself can lead to an error of at least 30 per cent. Furthermore, radioautographs have demonstrated a patchy distribution of the

radioactive iodine in the normal and hyperplastic gland, so that the radiation effect is not evenly distributed throughout the gland. However, using 7,000 r.e.p. as a base line we have avoided gross overdosage on administration of the first therapeutic dose. This in itself has kept to a minimum the proportion of those subsequently developing hypothyroidism. Additional doses are given on an empirical basis depending on the patient's clinical response.

In spite of the much larger dosage administered to patients with toxic nodular goiter, none developed hypothyroidism. In toxic diffuse goiter the occurrence of hypothyroidism is not an uncommon complication after I 131 therapy. Other clinics report an incidence of hypothyroidism that varies from 6 to 12 per cent. In our series, the incidence was 6 per cent. The hypothyroidism was frequently temporary; in those with a persistent clinical picture of hypothyroidism substitution therapy readily controlled the symptoms.

Radioactive iodine is effective in the treatment of patients in whom heart disease is the chief manifestation of their hyperthyroidism. Such patients should, in addition, receive whatever therapy is conventionally prescribed for any other patient with heart disease. Radioactive iodine has also been effective in causing abnormal cardiac rhythm to revert to normal without quinidine. Continued auricular fibrillation after radioactive iodine therapy has signified either persistent thyrotoxicosis or severe organic heart disease.

With a good clinical result there is invariably a reduction in the size of the thyroid gland, so that it is no longer palpable. In extremely large toxic nodular goiters, the rate of regression of the struma can be quite dramatic. Usually, though, there is incomplete resolution. In these toxic nodular goiter patients radioactive iodine therapy frequently causes a remission of the thyrotoxicosis without complete shrinkage of the gland. Histologic studies of specimens of thyroid glands obtained seven weeks and ten months after the administration of moderate doses of I 131 (3.5 millicuries and 14. millicuries) revealed no evidence of tissue necrosis or extensive fibrosis. At these levels of therapy with I 131 there does not appear to be evidence of pronounced radiation changes. However, with much larger doses such as are used in thyroid carcinomas actual radiation ablation of the thyroid gland and replacement by dense fibrous tissue have been observed.

SUMMARY

1. This report reviews the results obtained in the treatment of 390 hyperthyroid patients with I 131 over the five-year period between 1951 and 1956.

2. In toxic diffuse goiter, radioactive iodine caused a satisfactory remission and cure of hyperthyroidism in 90 per cent of all patients followed for at least one year. In toxic nodular goiter, satisfactory results were obtained but larger doses and a longer interval were required for a remission of the hyperthyroidism.

3. The only significant complication was hypothyroidism which occurred in six per cent of the total number of patients treated. This was readily controlled by the oral administration of desiccated thyroid extract.

(4) Radioactive iodine had proved useful in the treatment of patients in whom heart disease is the chief manifestation of their hyperthyroidism.

5. There was a mortality rate of 1.8 per cent due to hyperthyroidism in this series, all deaths occurring in cases with severe thyrocardiac disease.

201 Lyons Avenue

John A. Strazza, Jr., M.D.*

Bloomfield

Treatment of Arthritis with a Dextro-Amphetamine-Analgesic Combination

The emotionally depressed arthritic puts the doctor on the horns of a dilemma. Analgesics often depress people; yet arthritics need analgesics. A combination of amphetamine and an analgesic may be the answer.

In the conservative management of rheumatoid arthritis and osteoarthritis, the initial effort to provide relief of pain is combined with attention to mechanical problems. Rest, diet, counseling and exercise are simple measures which are often effective. Salicylates are the analgetic of choice, because they offer freedom from the side effects often encountered with the more potent pyrazolidines (phenylbutazone), steroids, or gold compounds. The latter may be reserved for sudden crises or for severe, sustained arthritis that does not respond to initial measures. Efforts, early in treatment, to alleviate somatic or emotional complications can be of considerable importance to many patients.

The general debilitation of advanced age frequently aggravates joint disease. The decrease in activity which is usual in elderly people tends to exaggerate the loss of mobility caused by the disease itself. Overweight, more frequently seen in middle aged or elderly patients, is an aggravating factor too. In many patients these somatic conditions produce psychic complications. Patients with a tendency toward hypochondriasis have a constant organic source of pain and disability to serve as springboards for their imaginations. The most prominent psychic factor aggravating the disease is a sense of apathy and helplessness approaching depression. Such patients may lack motivation to pursue therapy. The pain and disability of arthritis are made worse by emotional unrest, on the one hand, and may contribute to it, on the other.

The success of initial therapeutic measures thus depends upon an effective non-narcotic analgesic and upon alleviation of the emotional complications of arthritis. Potentiation of analgesic effects has been shown [1] to result from administering amobarbital with aspirin and phenacetin.[2] A combination of dextro-amphetamine sulfate, amobarbital, acetylsalicylic acid, and phenacetin† appeared to offer a number of important advantages for these patients. Reed [3] reported that this combination had greater efficacy than salicylates, aspirin, phen-

*Director of Arthritic Clinic, Saint Mary's Hospital, Passaic, New Jersey.

†Tradenamed as Daprisal® by the Smith, Kline and French Laboratories. The manufacturer furnished the experimental supply.

1. Wolff, H. G. *et al.*: Journal of Clinical Investigation, 20:63 (January 1941).

2. Goodman, L. S. and Gilman, A.: *The Pharmacologic Basis of Therapeutics.* Ed. 2. New York 1955, Macmillan. Page 141.

3. Reed, C. K.: International Record of Medicine 169:3 (March 1956)

acetin, and codeine combinations in relieving pain. Hanes[4] found the combination superior to aspirin-phenacetin-caffeine-codeine in relieving pain. He noted definite improvement in mood in patients suffering pain of various types including arthritis. Dextro-amphetamine gave promise of definite benefits in rheumatoid and osteoarthritis: elevation of mood for the depressed, and central nervous system stimulation for the chronically fatigued. The following study was conducted to determine how successful the combination might be, either as an initial treatment for arthritis, or as a full or partial replacement for phenylbutazone.

METHOD

THE study was conducted on 142 patients, 52 of whom had rheumatoid arthritis; 58, osteoarthritis, and 33 mixed arthritis (osteoarthritis superimposed upon rheumatoid). The group included 52 men and 90 women; their average age was 56.

Severity of the disease was rated according to these criteria:

Mild implied early, minimal structural damage, with pain that was a "nuisance," but was not severe enough to interfere with the functions of an involved joint.

Moderate means evidence of structural damage with pain contributing to altered function of an involved joint.

Severe reflects advanced structural damage with extreme pain contributing to the loss of most functions of an involved joint.

In 97 patients the disease was moderate or severe, in 45 it was mild.

TABLE 1. ARTHRITIS

Patients		Mild	Moderate	Severe
52	Rheumatoid	18	23	11
58	Osteoarthritis	14	26	18
32	Mixed arthritis	13	11	8
142		45	60	37

Of the 142 patients, 96 who had failed to respond previously to initial measures were receiving phenylbutazone in doses ranging between 100 and 400 milligrams daily, when they were included in this study. Twenty-six patients suffering mild arthritis had been receiving no medication prior to the study. The new medication was administered in two ways. In patients who had had no prior medication, it was the initial and only medication. In those who had been receiving phenylbutazone, it was administered to determine whether it would be a full or partial replacement of the more potent drug. The phenylbutazone dose, in most cases, was reduced gradually, as the combination appeared to maintain the patient. Where possible, complete replacement was effected.

Each tablet of the medication contains dextro-amphetamine sulfate, 5 milligrams; amobarbital, grains ½ (32 milligrams); acetylsalicylic acid, grains 2½ (160 milligrams); and phenacetin, grains 2½ (160 milligrams). The intial dose consisted of 2 tablets, three times a day, 5 hours apart.

BECAUSE of the potential effects of dextro-amphetamine in counteracting mental depression, overweight, and chronic fatigue, the incidence of these conditions at the start of therapy was noted. Depression, seen in 92 patients, was mild in 50, moderate in 42. Chronic fatigue was reported by nearly all of these patients. Overweight, noted in 63 patients, was moderate in 55, severe in 8. Both depression and overweight occurred simultaneously in 44 patients.

A careful record was made of the duration of therapy for each patient, since not only the success of therapy, but also the duration of its effectiveness, was important in the final evaluation of it. Therapy was continued from two weeks to 12 months, most of the patients being treated for six months or longer. The treatment was considered successful, if the combination achieved a significant relief of arthritic symptoms in previously untreated patients; if it could, when used alone, achieve results equal to those formerly achieved with phenylbutazone; or if—when used as a partial replacement for phenylbutazone—it enabled the patient to achieve equal relief with significantly lower doses of this potent drug.

4. Hanes, C. B.: American Practitioner and Digest of Treatment, 6:602 (April 1955).

RESULTS

TABLE 2 shows the complete results of this therapy. All of the 26 patients whose symptoms were mild and who had received no medication prior to the study were satisfactorily maintained on the combination as their initial and only medication. The combination was effective as a full replacement for phenylbutazone in 52 of 116 patients who had been receiving the more potent drug at the start of the study; it was effective as a partial replacement for phenylbutazone in 44 of the 116 cases (38 per cent). In 20 patients (17 per cent) replacement could not be effected, either partially or fully.

The combination served as a full replacement in more than half of the moderate cases of osteoarthritis (14 of 26) and of rheumatoid arthritis (13 of 23). It was successful as a full replacement in 44 per cent (8 of 18 cases) of severe osteoarthritis and in 27 per cent (3 of 11 cases) of severe rheumatoid arthritis. Its effectiveness as a partial replacement in the 44 cases cited above enabled those patients to reduce their consumption of the potentially harmful drugs to 60 per cent of the previous total.

Apparently in response to the dextro-amphetamine, as well as to the analgesic effect of the other agents in the combination, 74 of the 92 depressed patients experienced significant relief. Moderate depression was relieved in 31 of 42 patients, and mild depression, in 43 of 50. Psychogenic fatigue was notably relieved in nearly all of the patients who had presented this complaint.

Eight patients suffering severe overweight showed an average loss of 26 pounds over a four-month period; 55 patients suffering moderate overweight showed an average loss of 14 pounds over a similar period. Paradoxically enough, none of the patients with normal weights suffered an undesired weight loss.

The only important side effect produced by the combination itself was occasional epigastric distress, which was noted in 4 per cent of the patients. This condition was usually controlled by giving the medication after meals or with an antacid. Unwanted reduction of appetite was not marked, unless it was associated with epigastric distress. A few patients reported sleeplessness; this reaction was avoided by giving the last daily dose immediately after the evening meal.

COMMENT

THE combination produced excellent results in mild pain, and in moderate and severe pain as well. The incidence of full relief was higher in mild pain, but neither the severity

TABLE 2.

THE COMBINATION AS A PHENYLBUTAZONE REPLACEMENT

Arthritis	Severity	Patients	Combination Successful As Full Replacement	Combination Successful As Partial Replacement	Combination Unsuccessful	Results Succ.	Results Unsucc.
Rheumatoid	Mild	8	4	2	2	6	2
	Moderate	23	13	8	2	21	2
	Severe	11	3	4	4	7	4
Rheumatoid	Total	42	20	14	8	34	8
Osteoarthritis	Mild	4	4	0	0	4	0
	Moderate	26	14	10	2	24	2
	Severe	18	8	8	2	16	2
Osteoarthritis	Total	48	26	18	4	44	4
Mixed Arthritis	Mild	7	4	3	0	7	0
	Moderate	11	2	5	4	7	4
	Severe	8	0	4	4	4	4
Mixed Arthritis	Total	26	6	12	8	18	8
Grand Total		116	52	44	20	96	20

of an individual patient's pain, the structural damage, nor the limitation of function was an accurate barometer for predicting his response. Some patients suffering severe pain responded to the combination, while some suffering mild pain did not.

By using the combination as the only medication, the physician is assured that serious side effects will not occur; by using it as a partial replacement for phenylbutazone, he is assured that certain side effects (nausea, vertigo, insomnia) are less likely to occur. In line with the conservative approach to therapy, these initial measures are preferable to the use of other potentially harmful antiarthritic drugs.

In a disease as incapacitating and painful as rheumatoid or osteoarthritis, the high proportion of patients exhibiting depression and fatigue at the start of the study is not surprising. Gratifying changes in mental outlook were evident in many patients and these changes seemed to contribute a good deal to the effectiveness of the medication in relieving physical symptoms. The patients became more alert and active, showed better motivation, and, as a result, were more cooperative in therapy.

CONCLUSIONS

THE amphetamine-analgesic combination is of definite value in treating the pain and disability of rheumatoid and osteoarthritis. It is effective in relieving both mild and severe pain, and in counteracting the fatigue and depression which so often accompany pain. For some patients it is the only medication needed; for others, it can serve as a partial replacement for more potent drugs and helps to eliminate the side effects which may result from these drugs.

SUMMARY

1. A study was conducted on 142 patients with rheumatoid or osteoarthritis to determine the value of a preparation† containing dextroamphetamine sulfate (5 milligrams); amobarbital, (32 milligrams); acetylsalicylic acid, (160 milligrams); and phenacetin (160 milligrams). This combination was administered in 52 cases of rheumatoid arthritis, 58 of osteoarthritis, and 32 of mixed arthritis (osteoarthritis superimposed upon rheumatoid).

2. It was successful as the initial and only medication in 26 previously untreated patients; it was substituted for the full maintenance dose of phenylbutazone in 52, and was substituted for part of the maintenance dose in 44.

3. Consumption of phenylbutazone was reduced to 60 per cent of the previous total.

4. Seventy-four of the 92 depressed patients experienced a relief of symptoms.

183 Broad Street

Acne-Producing Drugs

The iodine contained in various thyroid and multiple-vitamin preparations may be responsible for the eruption of a moderately severe acne in adult patients, according to Dr. Louis G. Jekel of Phoenix, Arizona. All thyroid substances contain iodine (0.2 per cent is required in U.S.P. preparations). Such preparations can produce an acne eruption. Sometimes reduction in dosage will solve the problem; sometimes the thyroid must be discontinued entirely. Another source of acne-producing iodine is the potassium iodide present in many vitamin preparations with added minerals.—*Southwestern Medicine,* June, 1958.

Herbert Greenfield, M.D.

Newark

Postoperative Gastro-intestinal Roentgenography*

Pre-operative x-rays are, of course, commonplace in gastro-enterology. However, a postoperative x-ray film is also desirable to establish the defects due to surgery itself. These serve then as controls for follow-ups.

Gastro-enterologists and roentgenologists should be aware of the marked x-ray distortion following gastric and colonic surgery. Edema of the mucosa, distortion of the folds produced by surgery, suturing with turned in cuff or perigastric or pericolonic adhesions produce changes difficult to interpret at later roentgenologic studies. These postsurgical defects make it advisable if not mandatory to do early postoperative x-ray studies on these patients. If a stomach has been resected and a carcinoma widely removed it would be safe to assume that any x-ray distortion within three to four weeks is a result of the surgical manipulation. If similar changes were noted, then, a year or two later, they would occasion no anxiety concerning possible metastatic return or new growth. Similarly, if a carcinoma of the sigmoid has been removed and a temporary complementary transverse colostomy performed and then repaired, certain x-ray changes should be produced. There would be no cause for x-ray misinterpretation of a transverse colon colostomy defect for a transverse colon new growth if studies had been carried out in the early postoperative period. Equally important would be the x-ray changes resulting from or following a gastro-enterostomy or gastric resection for peptic ulcer. It is gratifying to note that these changes would not be called marginal ulcers but postoperative defects if a control x-ray study had been performed soon after the original surgery. It would be possible to dilate further on the intrinsic value of early postoperative studies following gastric or colonic surgery, but several specific case studies will be presented to augment this point.

CASE ONE

A 40 year old man had long-standing ulcer disease with multiple hemorrhages. Gastric resection was done following a fourth relatively severe hemorrhage. Films taken six weeks postoperatively revealed large concentric filling defects in the cardia of the gastric stump. This was rechecked two and three months later and although more pronounced and more clearly visualized, the pattern was essentially unchanged from the early postoperative study. It would be difficult to exclude a neoplasm of the cardia if studies had been done subsequently without these control films. Carcinoma of the stump of the stomach in resections for benign gastric or duodenal ulcers is being reported with increasing frequency. Again the necessity for postoperative control studies for any type of gastric or colonic surgery is emphasized.

CASE TWO

A 45 year old male complained of constipation associated with cramp-like abdominal pain and abdominal distention. Examination at that time was

*Read May 21 at the Annual Meeting of The Medical Society of New Jersey.



1. Six weeks after operation. Case 1.



2. Four weeks after operation. Case 2.



3. Two months after operation. Case 3.

essentially negative. A stool specimen taken from the end of the sigmoidoscope was positive for occult blood. On the right lateral wall there was a bean-sized polyp which appeared to be essentially benign. Barium enema revealed a constricting lesion in the sigmoid colon. The mucosal pattern through this area was also distorted. A postoperative film was taken four weeks following an anterior resection for proved carcinoma of the sigmoid. At this time there was noted a cuff-like edge with some narrowing of the lumen at the anastomotic site. The mucosa through this area was also somewhat distorted. If these films had been taken two or three years later it would be difficult to exclude a recurrent neoplasm. This pattern four weeks postoperatively fitted in with a postoperative defect. With this early postoperative film as a control guide x-ray misinterpretation as well as surgery was avoided.

CASE THREE

A 64 year old woman complained of dysphagia of two months' duration associated with substernal pain. There was mild food regurgitation and considerable weight loss. X-ray studies and esophagoscopy with biopsy revealed an adenocarcinoma of the stomach invading the esophagus. An esophagogastrectomy was done. Postoperative films two months after surgery showed a definite circular defect in the cardia as well as a cuff-like lesion at the site of anastomosis. The patient has been followed for the last two years without any change noted. Had the initial postoperative studies been done two years later it would be impossible to exclude a neoplastic regrowth and further esophagoscopy and possibly surgery would have to be considered.

CASE FOUR

A 50 year old male had a long-standing story of ulcer disease which included a ruptured duodenal ulcer, massive gastro-intestinal hemorrhage and pyloric obstruction for which a gastro-enterostomy had been performed. Since then he has had three subsequent bouts of hemorrhage. On a careful stomach rest program with prophylactic ulcer treatment he did well for eight years. Following psychic trauma he developed a massive hematemesis and melena for which a subtotal resection was done. Four weeks later these x-rays

(figure 4) were taken. There is a marked area of radiolucency in the cardia of the stomach above the anastomotic site. It has the appearance of two circular filling defects near the cardio-esophageal junction. Had these films been taken for the first time two or three years after surgery it would have been difficult to exclude a neoplasm in this area. Subtotal resection for benign ulcer does not guarantee immunity against either subsequent ulceration at the anastomotic site or the development of a carcinoma on the gastric stump side. With these early postoperative control films we are in a good position to appraise any subsequent change.



4. Four weeks after operation. Case 4.

These cases illustrate the value of repeat early postoperative gastric or colonic x-ray studies. Recurrent neoplasms at the site of anastomosis or adjacent tissue are being reported with increasing frequency. The development of a carcinoma at or near the stump of a previous gastric resection for a benign ulcer is reported also.

Some recurrent gastro-intestinal neoplasms manifest themselves by local gland invasion with secondary effect on adjacent vessels, nerves or organs. Others extend by distant lymphatic permeation metastasis or embolic phenomena and invade the pelvic pouch, cervical or axillary nodes, liver, lungs and bones. Appropriate physical examinations as well as chest x-ray, sedimentation test, liver function studies, weight loss and abnormal pain patterns may occasion sufficient suspicion to ferret them out. Today, Wangensteen and others advocate "second look operations" merely on suspicion of recurrent malignancies. The occasional salvaging of a patient with local or distant metastasis justifies this close rapport between patient and physician. The finding of a postoperative x-ray defect attributable to surgery should afford ample measure of comfort to justify its routine procedure. The findings of an occasional locally recurrent neoplasm whose x-ray pattern is obviously different from the previously established postoperative control rewards any expenditure of time. The findings of surgical defects following resection for benign tumors or ulcers would reduce the margin of error even in less serious conditions.

CONCLUSIONS

1. Gastric and colonic surgery can produce moderate to marked postoperative x-ray changes.
2. These defects are difficult to interpret roentgenologically from benign lesions or malignant regrowths.
3. Early postoperative x-ray studies following colonic and gastric surgery are strongly advised to serve as controls for future follow-up.

31 Lincoln Park

Trustees' Meetings

November 16, 1958

At its November 16 meeting, the Board authorized two members to attend the special conference called by the State Commissioner of Health with respect to hospital acquired infections. The Board also:

—Approved a suggestion of the President that instead of spending money for flowers at the time of the death of a Society official, the money be contributed to the Albert Kump Memorial Grant in the name of the deceased and that the family be so notified.

—Approved the suggestion that a plaque be presented to the incoming president each year upon his inauguration. Agreed, also, that at the next annual meeting, plaques be presented to each of the living, past presidents.

—Authorized a contribution of $25,000 to the American Medical Education Foundation.

—Agreed to cooperate with the Middlesex County Medical Society in defending a civil action brought against it by an osteopath in that county.

—Approved of New Jersey Senate Bill 231 which would give injured employees a choice of physicians in workmen's compensation cases.

—Approved of S-204 which would exempt certain organizations from liability in negligence cases but providing further that agents of such institutions will remain liable.

—Recommended that the Publication Committee seriously consider the discontinuation of advertising soliciting x-ray films for interpretation or skin diagnostic services without direct contact with the patient. The Judicial Council had ruled that such advertising in itself is not unethical although it might be distasteful to groups of members.

—Approved four proposals of the Special Committee on Civil Defense and Disaster Control. The first would encourage training programs for staff members through the disaster committees of the various hospitals. The second recommendation would encourage the State Department of Defense to acquire the services of Colonel Joseph R. Shaeffer who is about to retire from the Army and who is well-qualified in the Civil Defense field. The third recommendation asks the President of The Medical Society of New Jersey to communicate with the presidents of five county societies which do not have Civil Defense or Disaster Control committees and urge that such committees be established. The final section of the report recommended that there be a special section in the JOURNAL devoted to Civil Defense topics.

—Voted to support the nomination of Dr. William L. Vroom of our Bergen County component for the honor of being designated General Practitioner of the Year through the American Medical Association.

—Recommended that the Publication Committee discontinue advertisements for schools for medical technologists that are not approved by the American Medical Association.

—Expressed appreciation to Dr. Featherston and his committee for their work which led to simplified claim forms for accident and health policies and also for their work in cooperating with the Health Insurance Council in developing special articles on the various aspects of health insurance.

—Adopted the recommendations of a special committee on tuberculosis screening of school children which detailed the way in which such tuberculosis screening could be carried out.

Authorized the subcommittee on medical practice to start working on a "relative value fee schedule" patterned in general (although not necessarily in detail) after those now functioning in several other states.

—Approved the nomination of Dr. Irving Borsher to fill the vacancy on the board of trustees of the Medical Service Administration, caused by the recent resignation of Dr. Costello.

January 18, 1959

At its January 18 session, the Board of Trustees:

—Approved the assignment of Drs. Calvin, Klompus, Fuhrmann and Eckstein as a committee to meet with the State Commission to study Medical Care.

—Affirmed President Gardner's action in nominating Drs. Bowers, McCall and Buchanan to the National Foundation for their choice in designating physicians to select applicants for the Foundation's scholarship program.

—Approved President Gardner's acceptance of membership on the Advisory Committee to the Seton Hall chapter of the Student American Medical Association.

—Endorsed the naming of Drs. Duffy, Mahoney and Garber to attend the public hearing of the State Commission on Mental Health.

—Referred to the Subcommittee on Legislation a proposal to amend the Medical Practice Act so as to exempt from some of its prohibitory provisions certain technical personnel such as x-ray and laboratory technicians when operating under the specific direction of a licensed physician.

—Approved of adding to the Woman's Auxiliary Public Relations Program the following items:

Memorials to Doctors—Gifts of medical books by county auxiliaries to libraries to honor the memory of deceased doctors or their wives—all books must be approved by the county medical society in consultation with the librarian where the books are placed.

Medical Education Week—Cooperation on projects suggested by the A.M.A. and/or The Medical Society of New Jersey and approved by the latter (projects undertaken in this connection must be cleared by the local county medical society in each case).

—Recorded its approval and support of the AMA's recommendations regarding special health insurance coverage for people over 65 with modest resources and reduced incomes; recommended that Blue Shield with all possible speed prepare a contract offering coverage at reduced premiums to this group; and that the proposed contract be submitted to the Commissioner of Banking and Insurance for his approval at the earliest possible date.

—Recommended that New Jersey physicians cooperate in this by accepting the levels of payment established in the proposed new coverage.

—Welcomed Dr. Gardner's announcement that the AMA President-Elect, Dr. Louis M. Orr, would address our House of Delegates in April and authorized Dr. Gardner to organize a dinner at the Annual Meeting, with the Board as hosts, honoring Dr. and Mrs. Orr.

—Approved a report from Dr. Hurff concerning group-type life insurance for members. This recommended that the plan of the Nationwide Life Insurance Company be adopted as our plan.

—Received with gratification a report from Mr. Ruben Dalbec, AMA field representative, commending our Society for its excellently organized program of dealing with legislative matters.

—Heard a report from the Middlesex County Medical Society that, according to a recent poll, a majority of its members favor inclusion under Social Security.

—Approved the appointment of Messrs. Nevin and Backes and Dr. Featherston as our representatives to the AMA Regional Medico-Legal sessions in Washington in March.

—Concurred in the agreement of the Advisory Board of the Woman's Auxiliary creating a new category of "courtesy membership" in the Auxiliary.

—Established a clearing house of information on medical student loans and grants.

—Concurred in the Judicial Council's findings about solicitation by laboratories:

"The utilization of the services of certain out-of-state clinical or bioanalytic laboratories, which are soliciting business from New Jersey doctors on a 'package plan' basis, is in itself not unethical. However, the Council cautions member-physicians of the Medical Society to be certain that the services of all such laboratories are scientifically dependable, and that the charge reflected in the patient's bill is reasonable and proportionate with relation to the cost to the physician for the services rendered."

—Received the Council's clarification of its opinion that, under the Principles of Medical Ethics, all voluntary professional association of members of The Medical Society of New Jersey with osteopathic physicians is unethical. The clarifying statement follows:

"Voluntary professional association," in the sense in which the term is employed by the Judicial Council of The Medical Society of New Jersey, may be defined as "a relationship of professional cooperation freely entered into and maintained by licensed physicians who function as professional co-equals." In the case of such a relationship between a doctor of medicine and a doctor of osteopathy, the ethical violation derives from the fact that such relationship constitutes a tacit recognition on the part of the doctor of medicine of dependable scientific knowledge and competence in the doctor of osteopathy which, as a cultist, it must be assumed the doctor of osteopathy does not possess. It thus encourages confidence on the part of the public toward the doctor of osteopathy which is not merited or justified. This type of relationship is proscribed by the Principles of Medical Ethics of the American Medical Association, to which Principles The Medical Society of New Jersey adheres.

However, in the view of the Judicial Council of The Medical Society of New Jersey the proscription does not extend to include an individual, emergency, professional consultative contract entered into by a fully licensed doctor of medicine with a fully licensed doctor of osteopathy, and indulged because of critical need on the part of the patient for such knowledge as the doctor of medicine can bring to bear in his behalf, and the doctor of osteopathy cannot.

As long as osteopaths continue to embrace the osteopathic concept they will persist in practicing a method *not* founded on a scientific basis, and doctors of medicine will not be free to associate professionally with them. The choice is for the American Osteopathic Association—and all its affiliates—to make. Until osteopaths formally and officially abandon the osteopathic concept, they make it impossible for doctors of medicine to work with them regularly in the care of patients.

—Announced that it was the opinion of the Board of Trustees of The Medical Society of New Jersey that employees of any subdivision of the state government should be covered in the same manner as employees of any other corporation, *i.e.*, fees should be allowed for treatment of these cases in accordance with the statute governing workmen's compensation—

R.S. 34:15-15: "All fees and other charges for such physicians' and surgeons' treatments and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians' and surgeons' and hospital services;" that this opinion be forwarded to the Chief of the Claims Bureau, at the same time pointing out that this practice of arbitrarily adopting the Blue Shield schedule as the basis for all payments in workmen's compensation cases of state employees goes on in various state departments, particularly in the Claims Bureau of the Department of Law and Public Safety; and that a copy of the letter be sent to the Attorney General.

—Approved the report of the Special Committee on Traffic Safety to the effect that:

Drivers under the influence of alcohol constitute a serious menace that should be controlled by law. The special committee felt an exploratory meeting should be held with representatives of the Bar Association of New Jersey, the co-chairmen of the Subcommittee on Legislation, and the Society's legislative analyst. It is hoped that out of such a meeting a unified policy and adequate recommendations may be developed.

The special committee recommended that the proposed exploratory meeting be authorized. Upon motion by Dr. Bowers—seconded by Dr. Schretzmann, and carried—the recommendation was approved.

—Approved use of radio for statewide broadcastings of short "spots" to the public advising on the many phases of traffic safety. Through an offer from the Broadcasting Association, spot scripts are to be offered for approval of our Medical Society.

—Approved the nomination of Dr. Glennis S. Rickert to the MSP Board of Trustees.

—Authorized Dr. Hahn and Dr. Buchanan to attend the AMA's Conference on Aging in Washington this month.

—Endorsed Dr. Gardner's suggestion that all actions of the Board be reconsidered every five years if they are of a continuing nature.

—Heard the following report from Dr. Bowers and Mr. Nevin on their attendance at a conference on poliomyelitis in Trenton:

The purpose of the meeting was to discuss the high incidence of poliomyelitis which continues in New Jersey, and to consider by what means we could combat the indifference of the public toward the Salk inoculation program, specifically as regards children up to 10 years of age, and adult males from 20 to 29.

Dr. Bowers informed the conference that a recommendation was in the process of preparation by The Medical Society of New Jersey, originating with the Special Committee on Child Health, and advancing with the approval of the Subcommittee on Public Health, the purpose of which would be to encourage local boards of health and local private school authorities to require inoculation against poliomyelitis for all children attending school. All the conferees eagerly welcomed and concurred in this proposed recommendation, and asked that when such recommendation is adopted and sent to our component societies, copies likewise be sent to all agencies represented at the conference. It was evident that this recommendation, so consistent with the recommendations of the A.M.A.—is to become the basis for a campaign to encourage anti-poliomyelitis inoculations in New Jersey.

Upon motion by Dr. Sharp—seconded by Dr. Hamilton, and carried—the recommendation was adopted with such incidental changes in language as would extend its scope and content in conformity with proposals set forth by Dr. Bowers at the January 14 conference.

The recommendation as finally adopted is as follows:

The Medical Society of New Jersey—recognizing the fact that certain communities in the State do not require vaccination against poliomyelitis and diphtheria as a prerequisite to school attendance, and recognizing the fact that such requirement can only be imposed through the action of local Boards of Education and private school authorities in conjunction with the school physicians—recommends that each component county medical society review the situation within its boundaries and, where necessary, take steps to encourage local Boards of Education and private school authorities to adopt the requirement of immunization against diphtheria and poliomyelitis as a prerequisite for school attendance.

It is the further recommendation of The Medical Society of New Jersey that the component county medical societies also urge local Boards of Education and private school authorities to require the following inoculations as a prerequisite for admission to school: tetanus, smallpox, and pertussis.

National Inter-Professional Code for Physicians and Attorneys

This Code was prepared by the American Medical Association - American Bar Association Liaison Committee. It was adopted by the two associations in June and August 1958, respectively. It sets forth suggested rules of conduct for physicians and attorneys in their inter-related practice. It is hoped that state and county bar and medical societies will find the provisions of the national Code useful as guides in their efforts in this field.

The provisions of this Code are intended as guides for physicians and attorneys in their inter-related practice in the areas covered by its provisions. They are not laws, but suggested rules of conduct for members of the two professions, subject to the principles of medical and legal ethics and the rules of law prescribed for their individual conduct.

This code constitutes the recognition that, with the growing inter-relationship of medicine and law, it is inevitable that physicians and attorneys will be drawn into steadily increasing association. It will serve its purpose if it promotes the public welfare, improves the practical working relationships of the two professions, and facilitates the administration of justice.

MEDICAL REPORTS

Physicians upon proper authorization should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony.

The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.

CONFERENCES

It is the duty of each profession to present fairly and adequately the medical information involved in legal controversies. To that end the practice of discussion in advance of the trial between the physician and the attorney is encouraged and recommended. Such discussion should be had in all instances unless it is mutually agreed that it is unnecessary.

Conferences should be held at a time and place mutually convenient to the parties. The attorney and the physician should fully disclose and discuss the medical information involved in the controversy.

SUBPOENA FOR MEDICAL WITNESS

Because of conditions in a particular case or because of the necessity for protecting himself or his client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process.

ARRANGEMENTS FOR COURT APPEARANCES

While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon his time. Such arrangements contemplate reasonable notice to the physician of the intention to call him as a witness and to advise him by telephone, after the trial has commenced of the approximate time of his required attendance. The attorney should make every effort to conserve the time of the physician.

PHYSICIAN CALLED AS A WITNESS

The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness; and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

FEES FOR SERVICES OF PHYSICIAN

The physician is entitled to reasonable compensation for time spent in conferences, preparation of medical reports, and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions. The amount of the physician's fee should never be contingent upon the outcome of the case or the amount of damages awarded.

PAYMENT OF MEDICAL FEES

The attorney should do everything possible to assure payment for services rendered by the physician for himself or his client. When the physician has not been fully paid the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.

IMPLEMENTATION AT STATE LEVELS

In the event similar action has not already been taken this Code should, in the public interest, be appropriately implemented at state and local levels for the purpose of improving the inter-professional relationship between the legal and medical professions.

DISPOSITION OF COMPLAINTS

The public airing of any complaint or criticism by a member of one profession against the other profession or any of its members is to be deplored. Such complaints or criticism, including complaints of the violation of the principles of this Code, should be referred by the complaining doctor or lawyer through his own association to the appropriate association of the other profession; and all such complaints or criticism should be promptly and adequately processed by the association receiving them.

Commentaries on the National Inter-Professional Code as it Relates to The Medical Society of New Jersey

The code covers the relations between the attorney and the doctor before and all the way through the litigated case including the court's control of such case. In addition it suggests a procedural method for avoiding public criticism by a member of one profession against the other profession or any of its members.

MEDICAL REPORTS

The stress laid upon the importance of a complete medical report by the doctor to the lawyer is not only for the purpose of trial but, in addition, as an aid in obtaining a proper settlement.

The recommendation concerning the conference of physician and attorney in advance of trial is for the purpose of insuring that the rights of the client and patient may be fully known and adequately presented both at settlement conference and at trial.

SUBPOENA FOR MEDICAL WITNESS

The matter of assuring the attendance of the physician at court to give testimony at the trial is one of the most troublesome of all situations involving lawyers and doctors. Testimony is necessary to ascertain the damages claimed by the patient as a result of the alleged wrong and as well to establish whether the damages claimed were actually caused by the alleged wrong. For this reason the doctor is an indispensable witness at the trial. There are two causes for the difficulty experienced in obtaining the attendance of the physician during the trial. First, the demands of the doctor's practice and second, the doctor's misunderstanding concerning the distinction between the treating physician as a fact witness and any physician as an expert witness. As a treating physician the doctor is subject to a subpoena which may require him to attend, with or without pertinent records, to testify as to the facts in the case. In this regard the physician's duty is the same as that of any other person to respond to judicial process. On the other hand *no physician may be required by subpoena or otherwise to appear and testify as to his medical opinion* concerning a given set of facts and, in fact, even the treating physician may refuse to testify as to his medical opinion concerning a given set of facts. A distinction then between what is a duty to the court and what is not determines when the physician may demand a fee

of his patient-client and when he may not. As a treating physician testifying as to the facts, whether in response to a subpoena or not, the physician is entitled only to the usual witness fee. (Other arrangements may and should be made through courtesy in order to compensate any physician adequately for his time lost from his office.) Likewise, as an expert witness, whether giving his expert opinion as a treating physician, whether subpoenaed or not, or as a voluntary expert witness, the physician is entitled to a reasonable fee for such medical opinion. It is advisable for the physician to come to a satisfactory understanding with the attorney and his client concerning this matter prior to trial. Absent such understanding, and—although it is not desirable—it is proper for the physician to refuse to testify as to his medical opinion until he has been compensated for the same.

ARRANGEMENTS FOR COURT APPEARANCES

If after conference with the physician concerning the physician's attendance at the trial, a subpoena appears necessary the lawyer should always consider the professional demands upon the physician's time. The attorney can and must conserve the time of the physician by advising the physician at what time and for how long he will have to attend court.

PHYSICIAN CALLED AS A WITNESS

The comment with regard to the use of dignity and respect by the attorney and the physician in their treatment of each other when in court is likewise advice to the presiding judge that he should not permit either the lawyer or the doctor to embarrass or harass each other. Circumstances giving rise to such a situation of embarrassment can be avoided by the realization on the part of the physician that he must state the medical facts and/or his medical opinion frankly and with the realization that his testimony is to enlighten rather than impress or prejudice the judge or the jury.

FEES FOR SERVICES OF PHYSICIAN

Like the attorney, the physician should be compensated for his time and services, whether prior to the trial, by conferences or the preparation of medical reports and for actual court appearances. The warning that the fee should not be a contingent one indicates that to avoid confusion it is desirable that a satisfactory fee arrangement be made in advance of trial with a warning to the attorney that if he agrees to compensate the physician if the patient does not, he thereby becomes obligated to pay the bill of the physician upon the failure of his client to so respond.

In view of the fact that the physician has a duty to the court, representing the public, and must respond to a subpoena, which duty is superior to any that he may have to his patient or the attorney, he may not demand in advance of trial anything other than the usual witness fee of $1.00 before appearing to testify as to the medical facts as a treating physician.

It is incumbent upon the attorney to do everything possible to assure payment for services rendered by the physician. However, it is not required that any attorney guarantee to the physician payment by his client.

IMPLEMENTATION OF THIS CODE AT STATE AND LOCAL LEVELS

Although implementation at state and local levels is advisable because many doctors and lawyers are not members of either the American Medical Association or the American Bar Association, it should be borne in mind that any change in the wording of this code will nullify this current nationwide agreement which is the product of the efforts of similar committees of the American Medical Association and the American Bar Association after long, careful, mutual study for more than a year's duration in various locations throughout the United States. Different codes adopted in various localities would have a tendency to create uncertainty on the part of both lawyers and physicians.

DISPOSITION OF COMPLAINTS

Any criticism by a member of one profession against the other or any of its members tends to lessen public confidence in both professions. To avoid this the code suggests reference of such complaints, including any violation of this code itself, to the association of the criticized profession for its prompt attention.

Only by a full understanding on behalf of both professions as to the terms set out in this code will it achieve its purpose of promoting the public welfare, proving the practical working relationships between the two professions and facilitating the administration of justice. These commentaries are intended to create that understanding.

Offices to be Filled by Election

1959 Annual Meeting

Office	*Term*	*From*		*To*		*Incumbent*
President-Elect	1 year	April	1959	May	1960	F. Clyde Bowers, Mendham
First Vice-President	1 year	April	1959	May	1960	Jesse McCall, Newton
Second Vice-President	1 year	April	1959	May	1960	Ralph M. L. Buchanan, Phillipsburg
Secretary	1 year	April	1959	May	1960	Marcus H. Greifinger, Newark
Treasurer	1 year	April	1959	May	1960	Rudolph C. Schretzmann, Bergenfield
Trustees:						
1st District	3 years	April	1959	May	1962	Louis S. Wegryn, Elizabeth
3rd District	3 years	April	1959	May	1962	Lloyd A. Hamilton, Lambertville
5th District	3 years	April	1959	May	1962	David B. Allman, Atlantic City
11th Trustee	3 years	April	1959	May	1962	Luke A. Mulligan, Leonia
Councilors:						
2nd District	3 years	April	1959	May	1962	Joseph M. Keating, Passaic
5th District	3 years	April	1959	May	1962	Isaac N. Patterson, Westville
A.M.A. Delegates	2 years	Jan.	1960	Dec.	1961	William F. Costello, Dover
	2 years	Jan.	1960	Dec.	1961	Aldrich C. Crowe, Ocean City
A.M.A. Alternates	2 years	Jan.	1960	Dec.	1961	Samuel M. Diskan, Atlantic City
	2 years	Jan.	1960	Dec.	1961	Elton W. Lance, Rahway
Delegates and Alternates to Other States:						
New York						
Delegate	1 year	1960 New York Convention				William F. Costello, Dover
Alternate	1 year	1960 New York Convention				Levi M. Walker, Atlantic City
Connecticut						
Delegate	1 year	1960 Connecticut Convention				Lloyd A. Hamilton, Lambertville
Alternate	1 year	1960 Connecticut Convention				S. Eugene Dalton, Ventnor
Standing Committee:						
Publication	3 years	April	1959	May	1962	C. Spencer Davison, Salem

When the Patient Asks for a Social Security Report

Under social security disability provisions, benefits may be paid to disabled workers aged 50 to 65, and to their wives and children. Benefits may also be paid, regardless of age, to the dependent disabled sons and daughters of workers who have retired or died. Disabled workers under age 50 may have their social security records "frozen" to protect their own and their families' rights to future benefits.

The social security district office gives the applicant information about his rights, and advises him as to the documents he may need to support that application. One of the things he will need is medical evidence showing the extent of his disability. He is required to obtain this medical evidence at his own expense.

His social security office gives him a report form on which this medical evidence can be given. He is asked to take or mail this to his doctor. The form lists the medical facts needed to reach a decision as to whether the patient's impairment is severe enough to meet the definition of "disability" in the law. Use of the form is not mandatory; a narrative summary on the doctor's stationery may be given. The report may also be made on a form used by a hospital, institution, or agency, instead of on the social security form provided. Photocopies

of pertinent records are acceptable. The physician or institution returns the completed medical report by mail to the social security office.

WHAT INFORMATION IS NEEDED

The medical report should give the history, symptomatology, clinical findings, and diagnosis in sufficient detail to permit another physician, who will not examine the patient personally, to arrive at a realistic evaluation of the patient's remaining capacity for work.

If available, the report should also give information on the patient's condition at the time he says he first became unable to work.

Sometimes this may require more detailed medical data than the doctor has needed for his diagnosis or treatment of the patien 's condition. In the management of a heart patient, for example, such general terms as mild, moderate, or severe are of real significance. But more precise data are needed to measure the extent of cardiac pathology in determining disability for work. This data should include cardiac size as shown by x-ray or clinical examination, EKG findings, cardiac edema, the amount of dyspnea or angina (described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk), extent of renal involvement, response to therapy, *et cetera.*

The physician provides objective findings—not opinions. You will not be put in the position of determining whether your patient is or is not disabled. This determination is made by a highly trained team of physicians and vocational experts and is subject to review.

A well-prepared report speeds the payment of disability benefits to your patient and prevents the time-loss and effort of your being asked for additional data.

This is a service to your patients—please help them.

Life Insurance Plan for Members of the State Society

The Board of Trustees of The Medical Society of New Jersey has approved a special life insurance plan for submission to the members of the society. This five-year term policy is renewable for additional five-year terms on expiration prior to the 65th birthday. The policy provides double indemnity for accidental death. It also includes a permanent and total disability waiver of premium benefit after six months of total disability beginning prior to the 60th birthday. If the policy is issued or renewed through age 64 it continues for five full years and at its expiration or at any time during the term it is convertible non-medically to a standard form of insurance.

It is an individual policy with premium rates for all future renewals guaranteed the policyholder in his individual contract. It is convertible to standard non-term insurance without evidence of insurability required at any time.

The plan is issued on the basis of a simple application through age 64—not the usual comprehensive multi-question medical history questionnaire we usually associate with life insurance. There is no reduction in the amount of term protection at any age. The face value of the term policy or any of its renewals is constant at $10,000. When you get older and need the protection most, the policy remains at the same high level of protection. Up to four additional units of $10,000 each are available at the same rates and on the same plan subject to evidence of insurability satisfactory to the company and may be applied for by those eligible after the initial unit is issued.

Those whose initial applications are satisfactory to the company will have their coverage put into effect promptly. Those who are not insurable will have their policies issued, provided they are in full time practice of their profession, when 30 per cent of the state membership apply during a specified enrollment period, or if they are in the larger counties, such as Bergen, Hudson, Passaic and Essex, then their individual policies would be issuable when 30 per cent of their county society would apply during a special county enrollment period. (The company has agreed to allow concentrated county enrollment campaigns in any county that has a minimum of 175 members under age 65. Impaired risks in smaller counties or in counties that do not permit a special enrollment drive to be conducted will be issued policies when the statewide minimum participation of 30 per cent is achieved in a state over-all enrollment period.)

This special plan was designed especially for the Society by the E. & W. Blanksteen Agency, Inc., who have serviced our accident and health insurance program for more than 25 years. The rates are lower than can be ob-

tained individually for similar coverage.

The acceptable member of our society will obtain excellent coverage and policy provisions at a guaranteed rate much lower than he could obtain elsewhere, with this low rate reducible by dividends as declared by the company, and with sufficient support by our members, our impaired risk colleagues will also be able to obtain all the advantages of this fine plan at the same very low rate.

The plan is underwritten by the Nationwide Life Insurance Company of Columbus, Ohio, (with more than a billion dollars of life insurance in force) licensed in New Jersey. The company is affiliated with the Nationwide Mutual Insurance Company whose supplemental plan of accident and health insurance our society endorsed at the Annual Meeting last May, and is also affiliated with the National Casualty Company, who have underwritten our basic accident and health insurance plan for the past 25 years.

The enrollment of this plan of insurance will shortly begin. Brochures describing the plan in detail will be sent to every active member of the state society through age 64, together with an application for immediate completion and submission to the administrators. Individual policies will be issued immediately to the acceptable risks. Policies for the unacceptable risks will be issued subject to the enrollment requirements indicated above.

Committee on Aging

Summary of the Meeting of the Committe on the Aging
In Washington, D. C., January 24, 1959

Many agencies and organizations, Government and voluntary, are interested and active in determining the needs of our aging population and the measures to meet these needs. Each is interested in the matter of health. Each is looking to the medical profession for guidance. The over-all impression is the approach of Government functioning in the health program.

RECOMMENDATIONS FOR ACTION
BY OUR MEDICAL SOCIETY

(1) Creation and support of County Committees for the Chronically Ill and Aging.

(2) Encourage these Committees by stimulating physician participation in their activities.

(3) The County Committee should call meetings, inviting all agencies interested in the problem of the chronically ill and aging to (a) Study the problems and local needs of the chronically ill and aging; (b) Stimulate the development of any needed facilities, such as Home Nursing Services, institution medical care, Hospital or Nursing Home, Housing Facilities for Aged, and related problems, especially Information and Referral centers.

The problem of the Chronically Ill and Aging is one of the most pressing and important in today's Health Program.

WILLIAM H. HAHN, M.D., *Chairman*
Committee on the Chronically Ill and Aging
of The Medical Society of New Jersey

Diet Manual Committee

The Diet Manual Committee, which has been endorsed jointly by The Medical Society of New Jersey, the New Jersey Dietetic Association, and the New Jersey Department of Health, has been meeting regularly since June 1958 for the purpose of compiling and publishing an up-to-date *Diet Manual*. This will be distributed to all hospitals and nursing homes in New Jersey, so that a uniform list of diets can be maintained. It is the intention of this Committee to see that every doctor in the State receives this *Diet Manual*. Suggestions about this should be relayed to Dr. S. William Kalb at 416 Clinton Place, Newark. The phone is WAverly 3-1223.

S. WILLIAM KALB, M.D., Chairman

Obituaries

DR. STELLA BRADFORD

One of the country's pioneer physiatrists and rehabilitation experts, Dr. Stella Bradford died on January 20, 1959. Born in Montclair in 1871, she entered the field of social service in 1894, and was one of the earliest professional social workers in the state. She then returned to Smith where she became Associate Professor of Literature. In 1898, however, she decided to make medicine her career, and was admitted to the medical school of Cornell University at which she earned her M.D. in 1902. After an internship in Massachusetts, she returned to her native town and served the people of west Essex for the next half century.

She did general practice at first, but was early fascinated by the possibilities in the then brand new field of rehabilitation and eventually became director of physical therapy at Mountainside Hospital. She established the first visiting nurse service in west Essex, Montclair's first "fresh air school" and first tuberculosis clinic. Nine years ago she was accoladed by the Women's Service Clubs as the "outstanding woman of Essex County."

DR. RICHARD H. DIEFFENBACH

New Jersey lost one of its leading chest surgeons on January 3 with the death on that date of Dr. Richard H. Dieffenbach. Born in Newark in 1883, Dr. Dieffenbach was graduated in 1904 from the College of Physicians and Surgeons at Columbia University. After three years of graduate study here and in Austria, he opened an office in Newark in 1907 and he served the people of New Jersey for a half century. He was president of the medical staff of Clara Maass Hospital, a diplomate of the American Board of Surgery and also of the American Board of Thoracic Surgery, surgical director of the county tuberculosis sanitarium, and founder of Newark's first tuberculosis clinic. He was a welcome consultant in phthisiology and in chest surgery in many hospitals of northern New Jersey.

DR. HARRY FIALK

On December 27, 1958, Dr. Harry Fialk died at the New York hospital where he was Attending Surgeon. A native of Hudson County, Dr. Fialk was born in 1904 and was graduated in 1929 from Tulane Medical College. After interning in South Carolina he returned to his native county to go into private practice. He was an F.A.C.S. and was active in the affairs of the North Hudson Physicians' Society. Dr. Fialk served in the medical corps of the Army during World War II. He was Attending Surgeon at the North Hudson Hospital in Weehawken and at the Medical Arts Center Hospital in New York City.

DR. GEORGE R. HAMPTON

Dr. George R. Hampton, aged 80, a former staff physician at Greystone Park, died at his home in Orange, Connecticut, on November 30, 1958. Dr. Hampton served on the staff of The New Jersey State Hospital at Greystone Park from 1909 until his retirement in 1950. For many years he had been in charge of the x-ray and electrotherapeutic service.

Born in 1878, Dr. Hampton was a graduate of Georgetown University School of Medicine, Class of 1909. He served as President of the Morris County Medical Society in 1923 and was an Honorary Member at the time of his death.

DR. WILLIAM K. HARRYMAN

On January 13, 1959, Dr. William K. Harryman, director of traumatic orthopedic surgery at the Hackensack Hospital, died at his home. He was born in Long Island in 1895, and was graduated in 1919 from the University of Virginia Medical School. He then served in the Medical Corps of the Army in World War I and came to New Jersey to engage in private practice.

Dr. Harryman was active in civic affairs in Hackensack. He was a charter member of the Hackensack Lions Club and was its past president. He was also active in Masonic circles and in American Legion affairs.

Dr. Harryman was a Fellow of the American College of Surgeons, a member of the Bergen County Medical Society, and affiliated with several hospitals in the Bergen County area.

DR. PAUL HOSP

One of North Jersey's best known physicians, Paul Hosp died after a heart attack on January 20, 1959. Born in Newark in 1887, Dr. Hosp was graduated in 1913 from the medical school of Long Island University. He interned at St. Barnabas, and

became affiliated with nearly all the hospitals in Newark. He was a pioneer in the work of the Physicians' Chorus and was active in the affairs of the Essex County Medical Society. He was a family doctor with a wide practice, and was especially interested in pediatrics. From 1914 until his retirement in 1958—a period of almost half a century—Dr. Hosp served the adults and children of Essex County.

DR. LEO KELLY

At the untimely age of 50, Dr. Leo Kelly died suddenly on January 30, of a heart attack while quietly sitting at home watching television. Born in Trenton, Dr. Kelly was graduated in 1935 from the medical school of Georgetown University. After doing general practice in Perth Amboy, he was commissioned in the Army during World War II and rose to the rank of major. Becoming interested in ophthalmology, he became affiliated with the Wills Eye Hospital in Philadelphia. He was a member of our Mercer County Medical Society.

DR. WILLIAM M. O'CONNELL

On January 12, 1959, Dr. William M. O'Connell of Nutley and Weehawken, died at the age of 47. Born in Brooklyn in 1912, Dr. O'Connell received his M.D. degree in 1938 from the Medical School of George Washington University. He became interested in chest diseases and eventually became consultant at the Hudson County Hospital and also at the Pollack Hospital in Jersey City as well as St. Mary's in Hoboken. He was a Major in the Medical Corps in the Army during World War II, where he served in the South Pacific.

Dr. O'Connell had offices in both Nutley and Weehawken. He was active in the affairs of the Hudson County Medical Society. Dr. O'Connell was a Fellow of the American College of Chest Physicians.

DR. PHILETUS H. RILEY

Dr. Philetus H. Riley of Madison, died on December 28, 1958, at the age of 53. Born in Plainfield, he was graduated in 1937 from the New York Medical College, and after an internship in Providence, R. I., he entered the Coast Guard where he served for the duration of the war in the grade of lieutenant commander. At the conclusion of his military service he came to Madison to engage in the practice of gynecology and obstetrics, where he was on the staff of the Morristown Memorial Hospital.

DR. ANDREW RUOFF

On January 21, 1959, Dr. Andrew Ruoff, a well known and well loved figure in New Jersey medical and legal circles, died at the Doctors' Hospital in New York. He died on the eve of his 66th birthday. Dr. Ruoff obtained his M.D. from Fordham in 1917 and after interning at the Christ Hospital in Jersey City, entered private practice. Always interested in forensic problems, he attended law school while maintaining a busy private practice, and obtained an LL.B. degree from New Jersey Law School in 1927. He then became professor of Medical Jurisprudence at John Marshall College. He worked in the field of industrial medicine and surgery, as well as in legal medicine and was in frequent demand as a medicolegal expert.

DR. ALBERT V. SIMMONS

Born in 1884, Dr. Albert V. Simmons died on January 5, 1959, while visiting a sister in Ballston Spa. Dr. Simmons was graduated in 1907 from the medical school of New York University. A general practitioner, and a family doctor in the best tradition of that term, he was the beloved beneficiary of a testimonial dinner tendered to him in 1954 by 300 patients. More than 2000 residents of Essex County had been delivered by Dr. Simmons in his half-century career. He was a pioneer Maplewood physician, having been in family practice there when it was still called South Orange township. Dr. Simmons was affiliated with both the Irvington General and the Orange Memorial Hospitals.

DR. SAMUEL SPINNER

Dr. Samuel Spinner, well known in Union County medical circles died on January 20, 1959 at the Elizabeth General Hospital. He was born in Poland in 1890 and came to this country as a child. In 1917 he was graduated from the medical school of the University of London (England) and then went to Brazil where he engaged in general practice. In 1930 he came to Elizabeth, N. J., and engaged in practice in that city. He was interested in industrial medicine and rehabilitation and was frequently sought after in medicolegal matters for the determination of disability in which he had many decades of experience. He was a member of the Essex County Medical Society.

Announcements • • •

Orthopedic Seminar in Paterson

On Saturday, April 4, a unique seminar in orthopedic surgery will be held at St. Joseph Hospital in Paterson. Under the chairmanship of Dr. R. R. Goldenberg, the seminar will feature a star-studded faculty and a practical, informative program. The morning session (10 a.m. to 1 p.m.) includes papers on bone tumors, hip surgery and flexor tendon surgery. The afternoon papers will cover shoulder surgery, hip prosthesis and fibrous lesions of the bone. There is no charge. Obtain further details from Dr. Raphael Goldenberg of 588 East 27 Street, Paterson 4, N. J.

Ulcerative Colitis

An informative talk on newer procedures in the care of ulcerative colitis is scheduled for Thursday evening, April 16 at the University Club, 123 West 43 Street, New York. The pre-meeting dinner is at 6 p.m. and will honor Dr. Rupert Turnbull of Cleveland, the distinguished guest speaker. Dinner tickets are $10 and remittance should be sent to Dr. Norman Freund at 163 Ocean Avenue, Brooklyn 25, N. Y. Those wishing to attend the scientific program only (no charge) are asked to be at the club by 8:30 p.m.

The Challenge of World Health

On March 17 at the Hotel Suburban in East Orange, Dr. Michael Sacks will speak to the College Women's Club on World Health. Dr. Sacks is the WHO's medical liaison officer. He has had a distinguished career in the administrative, clinical and professional aspects of public health. A dinner preceding the talk is scheduled for 7 p.m. and the lecture will be at 8:30 p.m. Dinner tickets are $3. There is no charge for attending the lecture at 8:30 p.m. For further details, write to Miss Ella Hasenjaeger, Essex County Hospital, Belleville 9, New Jersey.

The title of Dr. Sack's talk is: "The Challenge of World Health."

Community Psychiatric Resources

Hold April 7—afternoon and evening. A that time the Academy of Medicine of Nev Jersey will schedule its workshop on the eval uation of community resources in psychiatry In addition to a general orientation, there wil be five small workshops and discussion groups

1. Facilities for the Disturbed Child. (Dr Brancale)
2. Care for People in Low Income Groups. (Dr Loeser)
3. What to do About the Recovered Psychotic (Mr. Weinberg)
4. Psychiatric Care and the Family Doctor. (Dr Novak)
5. Psychiatric Services in General Hospitals (Dr. Davidson)

These discussion groups are scheduled fo the 3 p.m. to 5 p.m. part of the afternoon. I the evening there will be summaries of the fiv groups and a talk by a distinguished guest For more details, write to Dr. Victor Par sonnet at 202 Clinton Avenue, Newark 5, N. J

Pediatric Oncology Course

A 3-day course in pediatric oncology is an nounced for the period beginning April 29 Registration fee is $35. The course is held a the Memorial Center, 444 East 68 Street, New York, and details may be obtained from th Chief of Pediatrics at that address. The cours covers the diagnosis and management of tu mors in children, including leukemia an reticulo-endothelioses.

Goiter Association Meets in Chicago

The 1959 meeting of the American Goite Association will be in the Drake Hotel, Chi cago, April 30, May 1 and 2. The program includes papers and discussion dealing with the thyroid gland, its physiology, pharmacology, pathology and therapy. For detailed program, write to Dr. J. C. McClintock at 149 Washington Avenue, Albany 10, N. Y.

Governor's Conference on the Aged

Governor Robert B. Meyner has called a Conference on Aging for Thursday, April 16, 1959, at the War Memorial Building, Trenton, starting at 10 a.m. This will be preparatory towards New Jersey's participation in the White House Conference on Aging in January, 1961. The Governor will deliver the keynote address, "The Senior Citizens as Seen from a Governor's Desk."

The conference will consider the responsibility of the individual, the community, and government in meeting geriatric needs. How can New Jersey tackle the special problems of the State's half-million citizens sixty-five years of age and older?

A galaxy of nationally known speakers will review all facets of the problem. Dr. David Price, Assistant Surgeon General, USPHS will discuss "Accent on Health." All persons interested in gerontology are invited to attend. For further details, write to Mrs. Eone Harger, Division on Aging, State Health Department, State House, Trenton 25, N. J.

Graduate Courses in Philadelphia

A series of short refresher courses will be given during May and June 1959, by the Children's Hospital of Philadelphia and by the Graduate School of Medicine, University of Pennsylvania.

Pediatric Advances. May 25 through 29, 1959. This includes clinics, demonstrations and panel discussions in selected aspects of contemporary pediatrics in which important advances are being made. Attendance is limited. Registration fee will be refunded if the registrant later finds it impossible to attend. $115.

Pediatric Hematology. June 1 through 5, 1959. Presented by Irving J. Wolman, M.D., Thomas R. Boggs, Jr., M.D. and other members of the Hematology Department of the Children's Hospital of Philadelphia. $125. This includes problems of blood grouping, neonatal jaundice, kernicterus and exchange transfusions.

An illustrative collection of 25 abnormal blood and bone marrow slides has been prepared. These are available for purchase. $10 for registrants; $15 for non-registrants.

Practical Pediatrics for physicians in New Jersey. This is on Wednesday afternoons from 1:00 p.m. to 5:00 p.m., March 18 through June 4. $100.

Inquiries should be addressed to Irving J. Wolman, M.D., Director of Graduate Education, Children's Hospital, 1740 Bainbridge Street, Philadelphia 46, Pa.

Gastroenterology Award

The American College of Gastroenterology offers a $1000 award for the best unpublished paper on research in gastroenterology or an allied field. Known as the Henry G. Rudner Award, it honors Dr. Henry G. Rudner, Sr., of Memphis, formerly chairman of the Board of Governors of the organization. The contest is open to all physicians.

All papers submitted must represent original and unpublished work in gastroenterology, or an allied field.

Entries for the 1959 award must be typewritten in English, double-spaced on one side of the paper and submitted in six copies.

The winning entry will be selected by the American College of Gastroenterology. The award will be made at the Annual Convention of the College, in Los Angeles, in September 1959.

The prize will be $750 plus an additional $250 for traveling expenses to present the paper at the Convention.

The paper must be received no later than May 31, 1959. Send the manuscript to Research Committee, American College of Gastroenterology at 33 West 60 Street, New York 23, N. Y. Further details may be obtained from the secretary of the College at that address.

Porphyria

New York University Graduate Medical School announces that the Howard Fox Memorial Lecture will be given by Dr. Louis A. Brunsting, on Tuesday, April 21, 1959, at 8 p.m. in the auditorium at 550 First Avenue, New York, New York. The speaker is head of the section of dermatology of the Mayo Clinic and professor of dermatology of the Mayo Foundation.

The title of his talk will be: "Porphyria Cutanea Tarda."

Epileptics May Marry

The ancient ban on marriage by epileptics has now been lifted in our state. On January 13, 1959, Governor Meyner signed bills introduced by Senators Ridolfi and Crane which removed "epilepsy" from the list of reasons for denying a marriage license. Known as Chapter 158 of the Public Laws of 1958, this new statute lines New Jersey up with most other progressive states.

Ophthalmology Courses

The following Graduate courses will be offered by the Institute of Ophthalmology of the Americas:

(1) Histopathology of the Eye, May 18 to 23, 1959.
(2) Practical Aspects in Perimetry; evenings, May 20, 21 and 22.

Further information may be obtained from the Registrar, Institute of Ophthalmology, 218 Second Avenue, New York 3, N. Y.

Conference on the Atom

While at our Annual Meeting in Atlantic City this spring, you will find it interesting to stop in at the Jefferson and Claridge Hotels to see the exhibits of the "Youth Conference on the Atom." This is the first of its kind in world history and includes a review of the medical aspects of atomic energy. The dates are April 27 through May 6. You may obtain a detailed program from Public Relations Department of the Atlantic City Electric Company at 1600 Pacific Avenue, Atlantic City.

Poison Control Centers

Knowing where to find a poison control center may save a patient's life. Note the center nearest to you. Keep the name and phone number handy on your desk:

Asbury Park: Fitkin Memorial—PR. 5-5500
Atlantic City Hospital—AT. 5-2112
Bridgeton Hospital—BR. 9-0113
Camden: West Jersey Hospital—WO. 3-8830
Elizabeth: St. Elizabeth's Hospital—EL. 5-3100
Englewood Hospital—EN. 3-3400
Flemington: Hunterdon Medical Center—Flem. 850
Lakewood: Paul Kimball Hospital—LA. 6-1900
Montclair: Mountainside Hospital—PI. 6-6000
Neptune: Fitkin Memorial—PR. 5-5500
Newark: Babies' Hospital—HU. 6-6200
Newark: Beth Israel—WA. 3-6000
Newton: Memorial Hospital—Newton 850
Orange Memorial Hospital—OR. 5-1100
Phillipsburg: Warren Hospital—WA. 5-1131
Point Pleasant Hospital—PP. 5-1100
Princeton Hospital—PR. 1-1900
Salem County Memorial Hospital—Salem 1330
Somerville: Somerset Hospital—SO. 8-4000
Teaneck: Holy Name Hospital—TE. 7-3070

OB-GYN Examinations

The next examinations, oral and clinical, in obstetrics and gynecology, will be held in Chicago from May 8 through 19, 1959. Notice of the time of each candidate's examination will be sent in advance.

Candidates who participated in the Part I Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

Deadline date for the receipt of new and reopened applications for the 1960 examinations is August the first, 1959. Candidates may submit their applications at any time before that date to Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

Camp for Diabetic Children

The New Jersey Diabetes League, an affiliate of the New Jersey Diabetes Association, is again sponsoring a camp for diabetic children. The camp was highly successful last summer. All physicians are urged to inform parents of diabetic children about the camp.

Camp Weahqua is in Johnsonburg, Sussex County. Inquiries should be directed to the New Jersey Diabetes League, Post Office Box 6133, Newark 6, New Jersey, Telephone Essex 3-6450.

Stool Specimen Containers

The State Laboratory distributes stool specimen containers. These containers have some buffered glycerol solution in them. This solution can undergo deterioration. This is probably due to evaporation during long storage. Containers in which the buffered solution shows color change and becomes viscid and shrunken in volume should *not* be used for stool specimens. They should be returned to the State Health Department for replacement. The normal appearance of the buffer solution should be clear, pale pink. The amount should approximate 2 or 3 fluid drams. Physicians are advised to order containers in such quantities that they will be used currently and not stored for protracted periods.

County Societies Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held on December 12, 1958 at the Children's Seashore House. Dr. Eugene Dalton, the President, was in the chair.

Dr. Molitch reported that his committee had a meeting on December 9, 1958. Dr. Victor A. Bressler attended and discussed the release of his "Package Medical Vacation" plan to the newspapers without prior approval from the Medical Society. It was the opinion of the Board of Censors that Dr. Victor A. Bressler "was in error." This report of the Board of Censors was disapproved.

Dr. Molitch then discussed the report of the Board of Censors concerning the corporation of physicians in forming and operating a drug store in Atlantic City. The doctors concerned had assured the Board of Censors that there would be no unusual control of the operation of the pharmacy by the physicians, that the profits will not depend on the number of prescriptions referred by the individual physicians, that there will be no rebates, that the group will not try to standardize their prescriptions, that they will not exploit the patient, and that they will guarantee free choice of drug store by the patient.

The Board of Censors called attention to a statement in the December 6, 1958, issue of the J.A.M.A. "The Judicial Council has noted a failure on the part of physicians to turn to the county societies concerning the application of ethical principles and the failure of the county societies to be more aggressive in developing a sound program of ethics."

It was apparently along these lines that the Censorship Committee deemed it necessary to prevent any situation which might arise concerning some of its members. The report concerning this matter was approved.

Dr. Robison Harley reported for the Public Relations Committee and stated that the weekly articles are starting to appear in the press. All doctors who would like to write an article should communicate with Dr. Steel.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society*, held February 10, at Bergen Pines Hospital, Paramus, was called to order by George Heller, M.D., President at 9:05 p.m., a quorum being present.

Dr. Campbell read the following names of regular members elected at the last meeting of January 13, 1959, and asked them to come forward to receive their membership certificates: Frances C. Nichols, Valentino V. Sica, Joseph A. Feudi, Frank S. Linane, Charles R. Moog.

The following Courtesy member was asked to rise: Adolfo Zier.

The Secretary read the following names, which have been approved by the Executive Committee for election to membership:

To Regular from Associate—Frank A. Franklin, Biagio V. Malfetano, Dorothy M. Snyder.

To Regular from Courtesy—Martin H. Perle.

To Regular by Transfer—Samuel M. Schlyen (from Passaic Co.)

To Regular—William A. Sibrans.

To Courtesy—Stanley J. Czepiel.

To Associate—Max K. Griffel.

To Honorary from Emeritus—William C. Williams.

It was moved and carried that the Secretary cast one ballot for the election of the slate.

After the election of these applicants the Secretary announced that the members of the Society had now exceeded 700 for the first time in its history (Regular 616, Associate 22, Courtesy 35, Emeritus 19, Leave of Absence 5, Honorary 4).

Emergency Medical Service Report—Dr. Donald B. Hull, Chairman of Public Relations Committee, presented the following report of the first 12 months of operation of the Emergency Medical Service:

Calls	530
Accepted by physicians	448
Cancelled by caller	76
Not accepted	6
Elapsed time —	
Less than 5 minutes	356
Between 5 & 10 minutes	73
More than 10 minutes	19
Calls by Police	152
Towns served	39

At the conclusion of this statistical report Dr. Hull noted that more than 100 members had participated in the service, that, contrary to past experience, there had been no newspaper reports or letters complaining that a doctor could not be obtained in an emergency. The distribution of towns served indicates that additional publicity about this service seems to be indicated in the northeast and northwest portions of the county. Dr. Hull recommended further distribution of the Emergency Medical Service gummed labels in this area.

Resolutions on the deaths of Dr. J. R. Helff and Dr. William K. Harryman were read by the Secretary and adopted.

Resolution re Social Security:—Dr. Irving M. Levitas was introduced. He pointed out to the members that at the October meeting a motion had been adopted by which the Delegates to the next

Annual Meeting of the State Society be instructed to bring Social Security coverage to the attention of the House. In further compliance with the wishes of the Society to be included under O.A.S.I., Dr. Levitas presented the following resolution:

Whereas, A two-to-one majority of votes cast by members of the Bergen County Medical Society in a recent poll of all members (exclusive of votes of members already included in Social Security Insurance coverage) indicated their wish to be included in the provisions of O.A.S.I., and

Whereas, Other component societies by similar recent polls of their members have determined the majority of their members are also in favor of inclusion in O.A.S.I., now therefore be it

Resolved: that the Delegates of this society to the Annual Meeting of The Medical Society of New Jersey to be held in 1959 be instructed to—

1. Urge the presentation of the question of inclusion under the provisions of O.A.S.I. of the members of The Medical Society of New Jersey to the House of Delegates of The Medical Society of New Jersey at its next Annual Meeting for discussion and definitive action, and

2. Cast their votes in favor of any resolution which would express the desire for Social Security Insurance coverage of The Medical Society of New Jersey, and are hereby directed to so vote.

Dr. Levitas then pointed out that it would be in order formally to request the Board of Trustees of The Medical Society of New Jersey to place this matter on the agenda of the House of Delegates at its next meeting and to inform the A.M.A. of the action taken. He then presented the following resolution and moved the adoption of both resolutions.

Whereas, Several component societies of The Medical Society of New Jersey have determined by recent polls that the majority of their members desire to be included under the provisions of O.A.S.I., and

Whereas, Several component societies of The American Medical Association have gone on record favoring such inclusion, now therefore be it

Resolved; that the Trustees of The Medical Society of New Jersey at its next Annual Meeting place on the agenda of the meeting of its House of Delegates a resolution favoring the inclusion of its members in O.A.S.I. for discussion and final adoption, and be it further

Resolved: that the wishes of the members of The Medical Society of New Jersey regarding Social Security coverage as determined by the House of Delegates be transmitted formally to the American Medical Association at its Annual Meeting in June, 1959.

After a lively discussion from the floor this motion was passed by a vote of 22 for adoption to 18 against (a number of members present abstained from voting).

At this point the Chair turned the meeting over to Dr. Tor Richter, Chairman of the Scientific Program Committee. Dr. Richter introduced Dr. J. E. Ross, Jr., who reminded the membership of the seminar on cancer arranged by the Graduate Education Committee to be held at the Bergen Pines Tuesdays, beginning March 10.

Dr. Richter then presented Mr. Edmond Nouri, who gave an extremely interesting talk on the value of careful estate planning by physicians.

Report of Nominating Committee:—Dr. Leo J. Fitzpatrick, chairman of the Nominating Committee, presented the following panel of Delegates and Alternates which had been placed in nomination at the January meeting:

Delegates	Alternates
Alfred A. Alessi	Stewart Alexander
Richard B. Berlin	Charles E. Clark
B. J. Ellmers	Joseph Cusmano
Walter J. Farr	Vincent C. D'Agati
E. F. Grueninger	Bernard Eisenstein
Donald B. Hull	Robert S. Frankel
William T. Knight	Joseph D. Gatti
Edward Mancene	Albert L. Higdon
J. Richard Mazzara	Cornelius J. Kraissl
Frederick L. Muller	G. Albin Liva
John L. Olpp	Robert L. Nutt
William L. Palazzo	Tor Richter
Anthony J. Persico	Howard J. Rosenbauer
Daniel B. Roth	John E. Schults
Anthony M. Susinno	Edgar M. Tennis
Felix H. Vann	Wilson D. Webb, Jr.

Member of M. S. of N. J. Nominating Committee —Delegate: G. Barton Barlow; Alternate: Frederick G. Dilger.

It was regularly moved and seconded by Dr. Johnson that the Secretary be instructed to cast one ballot for the election of this slate of Delegates and Alternates and after being duly seconded the motion was passed. The chairman then announced them to be elected.

Group Life Insurance Plan:—Dr. William L. Palazzo, chairman of the Insurance Committee announced that a plan of group life insurance underwritten by the Nationwide Insurance Company had been approved by The Medical Society of New Jersey for all of its members and that each member of this Society would receive in the mail a statement describing the coverage and an application for it. He urged careful consideration be given to subscribing for this protection. The Executive Secretary added that if 30 per cent of the membership of the State Society accepted this coverage, all members were eligible regardless of their physical condition or medical history; and that if this ratio was not attained by State Society action, any county society with more than 175 members could obtain the non-medical coverage on a county basis provided that 30 per cent of the members of the County Society applied for the coverage.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The second meeting of the season of the *Camden County Medical Society* was held on January 6 in the auditorium with the President, Elic A. Denbo, M.D., in the chair, and 46 members present. Dr. August S. Rivero was presented to the Society after taking the oath of membership and signing the register. The following were unanimously elected to membership: Drs. Joseph L. Azorsky, Peter T. DeMarco, David H. Black, James E. Brennan, Harry C. DeVallinger, John W. Fessman, 3rd, Memorio Galindo, Robert S. Gamon, Jr., Arthur A. Hartley, Marvin E. Herring, Mustapha M. Khan, S. Lee Kuensell, Paul D. Rahter, Jose A. Sosa, Robert J. Trollinger and Charles J. Volpe. Elected to Emeritus membership were: Drs. Casper M. Beideman, Samuel S. Butler, Arthur J. Casselman, Charles F. Hadley, Mahel S. Haines, David S. Rhone and Ernest B. Shaw.

The guest speaker, Dr. Halsted R. Holman, Assistant Professor at the Rockefeller Institute for Medical Research, spoke on "Recent Developments in Research on Rheumatoid Arthritis and Systemic Lupus Erythematosus."

The Secretary read a memoir on the passing of Dr. William Shemely, Jr., prepared by Dr. Eugene A. Meyer and a similar one on the passing of Dr. Charles F. Becker, prepared by Dr. Reuben L. Sharp.

Dr. Durham, chairman of the Executive Committee, presented a synopsis of the actions of the Executive Committee in its interim meetings. He also discussed the rheumatic fever control study and the distribution of penicillin.

Dr. Pratt stated that there have been many changes in the Constitution and By-Laws since it was last published. He suggested that there be a reprinting with these corrections. This was passed and the Secretary will arrange for the republishing.

The meeting adjourned at 10:40 p.m.

EUGENE H. KAIN, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on February 3. Dr. John J. Bedrick presided.

Guest speaker for the evening was Dr. John J. Calabro, Assistant Professor of Medicine, Seton Hall College of Medicine. Dr. Calabro spoke on "Rheumatoid Disease." There was an interesting discussion from the floor.

The Society passed the following resolution:

Whereas, there is no minimum fee schedule in Hudson County; and

Whereas; it would be to the advantage of the physicians in Hudson County to have such a uniform fee schedule; and

Whereas, there are appearing in Hudson County numerous pre-paid medical plans other than for the indigent; and

Whereas, it would give our Exeeutive Committee a basis upon which to negotiate with the proponents of such plans; therefore

Be It Resolved, that the Hudson County Medical Society set up the following minimum fee schedule

Office call	$5.00
Home call	7.00
Home eall, after 10 p.m.	10.00

and

Be It Further recommended that the Hudson County Medical Society print under its seal such posters and distribute them in the County to be displayed in physicians offiees.

Dr. Herbert E. Cassidy of Bayonne was elected to Active membership.

CLEMENT M. JONES, M.D.

Reporter

Mercer

Officers for the year 1959-1960 (who will assume their positions on May 13, 1959) were elected at the Society's February 11 meeting:

President, Dr. John A. Kinczel; Vice-President, Dr. Peter J. Warter; Secretary-Reporter, Dr. Ralph N. Cagan; Treasurer, Dr. Joseph R. Burns.

Announcement was made of the deaths of Drs. Henry J. Austin, Leo J. Kelly, and Albert E. Magson.

The following were eleeted to Active membership: Dr. Frank W. Johnson, on transfer from Montgomery County, Pennsylvania, Medical Society, and Dr. Harold E. Morris.

Other actions taken at the February 11 meeting included:

Approval of the following statement: "The Mercer County Component Medical Society recommends to the boards of education of Mercer County's public, parochial, and private schools that anti-poliomyelitis immunization be made a prerequisite to entrance into the beginning grade of eaeh school system."

Submission of a proposed amendment to the Society's Constitution relative to Associate Members.

Adoption of an Inter-Professional Code for Physicians and Attorneys.

LAWRENCE I. BONIN, M.D.

Reporter

Middlesex

Under the chairmanship of Dr. George J. Kohut, its president, the *Middlesex County Medical Society* held its regular monthly meeting at the Roosevelt Hospital, Metuchen, January 21.

Dr. Shangold introduced Dr. Herbert Pollack, Assistant Professor of Clinical Medicine, New York University Graduate School of Medicine, who spoke on "Coronary Artery Disease and Nutrition." The relationship between nutrition, especially fatty acid, and caloric intake to coronary diseases was ably and clearly brought out. Many new ideas on the therapy of obesity were given to the Society as a result of Dr. Pollack's clinical studies in this and foreign countries.

Dr. Kohut announced that a new drive for Group Hospitalization and Medical Surgical Insurance will open March 15, and definitely close April 15.

Dr. Kohut requested a sum of $350 be alloted for the County Medical Society's expenses at the Annual Meeting of The Medical Society of New Jersey in April, 1959. This was unanimously approved.

The meeting was then adjourned.

DONALD T. AKEY, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held in cooperation with the Passaic County Heart Association on January 20 at 9:00 p.m. at the St. Joseph Hospital in Paterson. This was the third Meyer Notkin Memorial Lecture held in co-sponsorship.

Dr. Theodore K. Graham, President of the Passaic County Medical Society, welcomed those attending, and presided over a brief session of the Society.

The following were elected to Active membership: Drs. Elaine G. Kass and Bernard H. Sklar, both of Paterson; elected to Associate membership was Dr. Jose D. Perez of Passaic.

The meeting was then turned over to Dr. Ben W. Berner, President of the Passaic County Heart Association. He greeted the group and spoke of the devoted interest of Dr. Meyer Notkin in the Heart Association. He said he felt that Dr. Notkin would have derived a great deal of satisfaction in the result of his efforts.

Dr. Berner invited Dr. Gordon W. Howe, Program Chairman of the Passaic County Heart Association, to introduce the guest speaker, David Scherf, M.D., Professor of Clinical Medicine, New York Medical College. Dr. Scherf's subject was "Management of Common Cardiac Arrhythmias." A question period followed.

At the conclusion of the program, a collation was served by the St. Joseph Hospital.

DAVID B. LEVINE, M.D.

Reporter

Salem

The *Salem County Medical Society* held its regular monthly meeting at the DuPont-Penns Grove Country Club on January 17. Dr. Charles E. Gilpatrick was the presiding officer. A motion was passed recommending the administration of a fourth dose of Salk vaccine. It was suggested that this dose be given a year after the third injection, in an effort to provide a higher level of immunity against polio.

Dr. Isadore Lipkin, Chairman for the Salem County Diabetes Detection program announced that 994 tests were completed in the Elmer and Salem Hospitals and physicians' offices. This included tests on 140 children. Ten new cases of diabetes were discovered by this program.

Following the business meeting, three representatives of the investment firm of Reynolds and Company, Vineland, led a very informative period of discussion on the present day trends in business and the operations of the New York Stock Exchange.

Mr. Jerry Brown, office manager, outlined the business categories of the national economy.

Along with his associates, Jay H. Allen of Woodstown and H. C. Berry, Mr. Brown answered many questions pertaining to the operation of the various stock exchanges and the method of purchasing stocks and bonds. The discussion period suggested that the trend of the average doctor was to be investment minded.

G. F. REICHWEIN, M.D.

Reporter

Book Reviews • • •

Cancer and the Atomic Age. Clement A. Tavares, M.D. New York 1958. The Vantage Press. Pp. 198. ($3.50)

"The energy theory of cancer" writes Dr. Tavares "is the long-sought-for common denominator of the cancer problem." The author believes that cancer is due to an increased concentration of energy within cells. Heat, irritation, and radiation, all being energy-builders, are all carcinogenic. He warns against pollution of the air by automobile exhaust fumes, nuclear fallout, industrial gases, dusts, hot food and tarred highways—all of which, he suggests, might be cancer-provoking. He is impressed by the viral theory of the cause of cancer, and works this into his energy hypothesis by stating that "the viral bodies are in resonance with ultraviolet radiation, absorbing such energy freely." He believes that cancer can be treated by energy-removing devices such as cryotherapy. He also recommends a high protein diet as "ideal for cancer prevention" which seems odd, since I was taught that protein is an energy-producing food. He presents a list of measures for avoiding cancer, which includes a warning to avoid living in brick houses, and to shun hot baths, suntan lotion, tarred highways, hot drinks, and excessive travelling.

Dr. Tavares is bitter about A bomb and H bomb radiation, and warns that "man would be wise to stop experimenting with cosmic forces which could destroy him." He characterizes his energy theory of cancer in these terms: "The energy theory possesses the remarkable attribute of being able to explain all observations concerning causation whether they appear to be conflicting or inconsistent."

ULYSSES M. FRANK, M.D.

Insomnia and its Relation to Dreams. By Leonard Gilman, M.D. Philadelphia 1958. Lippincott. Pp. 237. ($4.95)

A country that produces a million pounds of barbiturates every year is obviously one in which insomnia is taken seriously. And that's the U.S.A. And any refugee from a sheep turnstile can confirm the fact that insomnia is no laughing matter. Dr. Gilman points out that insomnia originates from within—and from unconscious sources at that. So there is really no sense in treating it from without—by changes in posture, by drugs, by plugging up the ears or by any external manipulation.

Dreams are considered wish fulfillments or fear expressions and half the book is devoted to explaining how dreams originate and how they are interpreted. Some of the author's concepts are truly original—particularly his ingenious way of tying up dream mechanisms with insomnia. There is a solid 50-page chapter on the treatment of insomnia, which reviews psychologic, pharmacologic and procedural technics. The book closes with a graceful chapter on the mystery of sleep.

ABRAHAM LEFF, M.D.

The Doctor Business. By Richard Carter. Pp. 282. Garden City, N. Y., 1958. Doubleday. ($4.00)

At the cost of somewhat overstating his case, Mr. Carter delivers a scathing indictment of the "fee for service" system. He says that this keeps people from seeking good medical care, and that it gives the doctor too much interest in the economics of medicine. Here is his theme song: "Abuses of the patient's person and pocketbook through unnecessary surgery, excessive fees, and professional neglect are direct consequences of organized medicine's dollar policies." Mr. Carter's culprit is not the individual doctor, but the American Medical Association. He has unbounded admiration for the American College of Surgeons, which he sees as a relatively socially-minded and liberal organization compared to the American Medical Association.

He charges the AMA with dragging its feet in its quest for better medical standards—the phrase he uses being "to track down the butchers in their midst." This quotation gives a general idea of the tenor of the book. He does not see why physicians should be allowed to exercise control over medical care. In no other area of modern life is the vendor of an indispensable service so free of social restraint. He says that organized medicine has compelled the citizens to let physicians behave as if they owned the hospitals. He exempts from this indictment such institutions as the Mayo Clinic and the Henry Ford Hospital, which "being completely staffed with salaried physicians are beyond the influence of organized medicine and are, therefore, not typical."

Mr. Carter implies that every doctor must belong to the medical society or be ostracized, and for this reason the medical society is able to exercise a tyranny over the members. He disposes of Blue Shield and similar health insurance policies in

these words: "It offers endless opportunities for chiseling on the part of both dispenser and receiver and it tends toward the corruption of both." He further adds that organized medicine behaves as if the purpose of health insurance were to insure the physician rather than the patient. He says that complete health insurance is entirely possible from an actuarial standpoint. He asks: if life insurance can be effective and profitable, why not health insurance? Apparently, Mr. Carter does not realize that death is predictable whereas illness is not. He charges that most physicians levy surcharges on top of the payment which they receive from Blue Cross so that the patient is fooled into thinking that he is buying medical coverage whereas he is not. He tells of a surgeon who normally charges $150 for an appendectomy, but whose fee is $300 if the patient is insured. He collects $150 from the insurance company plus another $150 from the patient. This, he believes, is typical of the way private practitioners, handle this.

Mr. Carter admires the welfare fund of the coal miners and says that the attitude of organized medicine toward this shows that "organized medicine has failed to control professional sadism and larceny. Organized medicine casts its lot with the fee."

He is aware of the medical society's efforts to prevent abuse through the grievance committee. "The grievance committees," he says, "serve as additional armor for the incompetent or calloused physician." He has only scorn for organized medicine's effort to improve its public relations through the advice of public relations counsel. He applauds one of the plans set up by a California county medical society, stating, "Instead of pretentious public relations, this medical society provides a superior medical service plan."

The book is interesting, well-written, and provocative. Perhaps Mr. Carter's egregious overstatement of the case is necessary to get attention. The book is bound to damage the standing of organized medicine in the eyes of the public. Attacks like this, however, cannot be met by simply closing eyes and wishing that they would go away. They must be answered.

HENRY A. DAVIDSON, M.D.

Tumors of the Lungs and Mediastinum. By B. M. Fried, M.D. Philadelphia, 1958. Lea and Febiger. 467 pp. 340 Illustrations. ($13.50)

This comprehensive monograph covers its intriguing subject so adequately that it will serve as a useful reference to all interested in chest diseases. Illustrations are numerous, well chosen and effectively emphasize and support the facts.

The greater portion of the book is devoted to cancer of the lung. This is well and completely presented. The author has chosen competent specialists as contributing authors to deal with the more technical phases of this increasingly dreadful problem. Varying points of view and evidence as to etiology is fairly presented but the author merely points to the "muddied waters" arising out of the controversy as to the role of cigarette smoking. He leaves the decision up to the reader. Another controversy is the role of trauma in the etiology of cancer of the lung. The author leaves no doubt that there is none. He prefers an exploratory thoracotomy when the diagnosis is in doubt and disapproves needless biopsy and thoracoscopy to establish a diagnosis. Two chapters are devoted to metastasis; one, discusses spread from the lung to almost every organ of the body and the second discusses the spread of cancer from different parts of the body to the lungs.

The rare tumors are briefly but sufficiently discussed along the same general scheme. The chapter on mesothelioma is interestingly presented but its histogenesis remains controversial. The remaining one hundred pages are devoted to that facinating group of tumors that arise in the mediastinum such as the lymphomata, the thymoma and the teratoma.

At the end of each chapter is a reference which contains an excellent index of authors. This is a splendid guide to all interested in diseases of the chest. The writing style presents the subject with unusual clarity. No library will be complete without this excellent addition.

HENRY A. BRODKIN, M.D.

A Physician Looks at Psychiatry. By Jacques M. May, M.D., New York 1958. The John Day Company. Pp. 189. ($3.50)

A distinguished European surgeon, now a consultant in tropical medicine, Dr. May drafts a harsh indictment of American psychiatry. He asserts, in effect, that psychiatry is a captive of psychoanalysis, that it is ignoring organic factors in mental disease, that it offers its best services to mild cases where there is least need for help. He points out the giant strides made by other medical specialties, and charges that psychiatry has made practically no advance at all because it has divorced itself from basic medicine. The picture is badly overdrawn, and many of his statements are demonstrably erroneous. His description of the "official classification" of mental disease is incorrect; his charge that students of psychiatry can't get anywhere without lengthy psychoanalytic training is untrue. He estimates that two-thirds of American psychiatrists are concerned only with "cases mild enough for office visits with bank accounts large enough to afford them." This intemperate charge will win no converts to the cause of a totally organically-oriented psychiatry. But for all its extremism, the book is challenging to read, well-written and vigorous in its presentation.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

March, 1959 • Vol. XXXII—No. 3

THE CONTROL OF ACUTE RESPIRATORY DISEASE IN INDUSTRY—*WITH SPECIAL REFERENCE TO INFLUENZA*

One quarter of the lost time in industry is attributed to respiratory diseases. For some of these, effective vaccines have been developed. Children are the main source of respiratory illnesses among adults.

The significance of respiratory diseases as a cause of absence in industry has been well documented by many studies. Acute respiratory diseases account for nearly half of the incidence of absence and at least one quarter of the total lost time. This is estimated as amounting to 150 million work days annually, in addition to the reduced efficiency which results from employees who are on the job in various stages of illness. From the viewpoint of cost alone industry should have a considerable interest in health maintenance and disease prevention.

ABSENTEEISM

Despite the fact this country is enjoying the highest level of health in the world, the direct cost of absence owing to illness is increasing. This undoubtedly reflects the trend toward broader coverage, increased scale of benefits and a tendency for more liberal interpretation of what constitutes justifiable cause for absence.

Let us consider briefly the complex subject of absenteeism. The term implies a medical problem when we know in fact that there are many other factors involved including personal motivation, family responsibilities, pay treatment, *etc.* Measures directed solely to the control of diseases as such quite probably never will provide the entire answer. There is good reason to believe that there is a strong interrelationship between a man's health, behavior and job performance with the kind of man he is, where he comes from, what he wants and needs, what he is facing now in his home and personal life and what he has faced in the past. There is little doubt that when science has made available to us the means for prevention and control of the common cold, the favorable impact on absence will be spectacular.

RESPIRATORY DISEASE

Considerable progress has been made in the study of acute respiratory diseases during recent years. There is good reason to believe that as more money is channeled into research in this field, we will have even more precise diagnosis and more knowledge of prevention and control.

At present the causative agents of respiratory infections can be identified in approximately 50 per cent of all cases occurring in children and adults, according to the Scientific Advisory Committee of the Common Cold Foundation. These identifiable agents include the influenza viruses, the adenoviruses, the J.H. virus viral agents 2060 and Myxo viruses.

In the infections caused by these different viruses an immune response occurs, followed by protection for variable periods of time. The scientists believe then, that properly prepared vaccines similar in the antigenic composition to the viruses in question would have an immunity and protective value. This has been shown to be true for influenza and for types three, four and seven of the adenoviruses.

There remains a sizeable segment of upper respiratory tract infections, most if not all of which are caused by viral agents. It is in this segment, the most frequent of all, the common

L. Holland Whitney, M.D., *Medical Director, American Telephone and Telegraph Company, Industrial Medicine and Surgery, October, 1958.*

cold falls. At the present time there is no means of controlling this group.

The most effective way to use immunizing agents is during childhood which is the normal time of life in which the largest number of respiratory infections occur. In a study made in Cleveland it was found approximately 75 per cent of the acute respiratory infections were introduced into the home by the children.

If we should then only attempt to protect population groups by vaccinating the adult members, the source of these infections which reside mainly in children would not be affected. The control and prevention of acute respiratory infections are indeed complicated.

At this stage of our knowledge on the control of respiratory diseases in industry we are limited to three general methods of approach. The first avenue of control might be considered under the general heading of health education, which includes personal hygiene and such simple procedures as covering the sneeze, washing the hands before eating and maintaining that intangible something known as general body resistance. Adequate control of the environment by proper ventilation, heating and good housekeeping is also important. And finally the specific measures already available through vaccines, antibiotics and the sulfa drugs can be considered.

INFLUENZA VACCINE

Some industries have been offering the polyvalent influenza vaccine to their employees each fall for the past eight or 10 years. The impracticality of accurate prediction of an epidemic and the uncertainties of the strain and type of virus likely to be responsible have prompted others to discontinue this procedure. Vaccines effective against the adenovirus infection also have been developed. Doctor Maurice Hillman, who developed the bivalent type of vaccine, does not recommend its use at this time in the adult civilian population because of the low attack rate. He is, however, enthusiastic about the results obtained in reducing the incidence rates for febrile respiratory illnesses in military recruit populations.

This brings up another point. I believe we in industrial medicine have a real obligation to take an increasing interest both in support of scientific studies and in cooperative ventures to evaluate the progress made.

During the fall of last year over 400,000 Bell System employees were vaccinated against the type A-Asian strain of influenza. The incidence of significant reaction to the vaccine was negligible. At our headquarters location an analysis of the absences in excess of seven days due to all respiratory diseases among vaccinated and unvaccinated employees during the months of October and November shows a ratio of 1.0 to 4.2 respectively. This represents a group of nearly 9,000 employees, approximately two-thirds of whom elected to be vaccinated.

These preliminary reports are presented only as an indication of apparent results, and not as a finished or scientifically validated piece of research. Our experts assure us that the difference between the two groups is statistically significant.

As preventive measures against respiratory disease become available, industry is in a position to reach a considerable segment of the adult population. The particular industry's decision on whether to do so will be governed by many factors which include costs, anticipated results, company policy and the potential threat of an epidemic. Perhaps one of the most important considerations will be the possible impact of the disease on the productive capacity of the industry and the significance of this to the welfare of the public which it serves.

The goal still ahead is a challenge to all of us, and in reaching it there is ample opportunity for cooperative efforts between industrial medicine, private medicine, and both voluntary and public health agencies.

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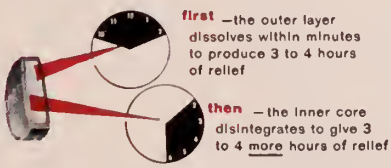
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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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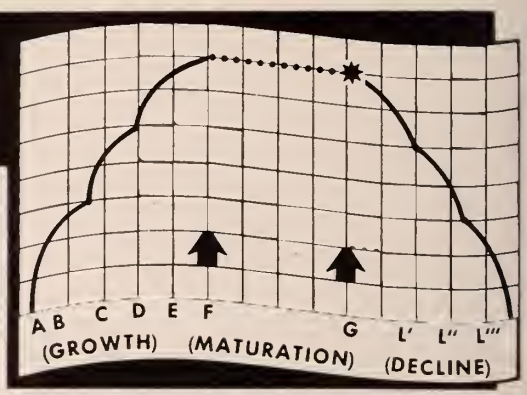
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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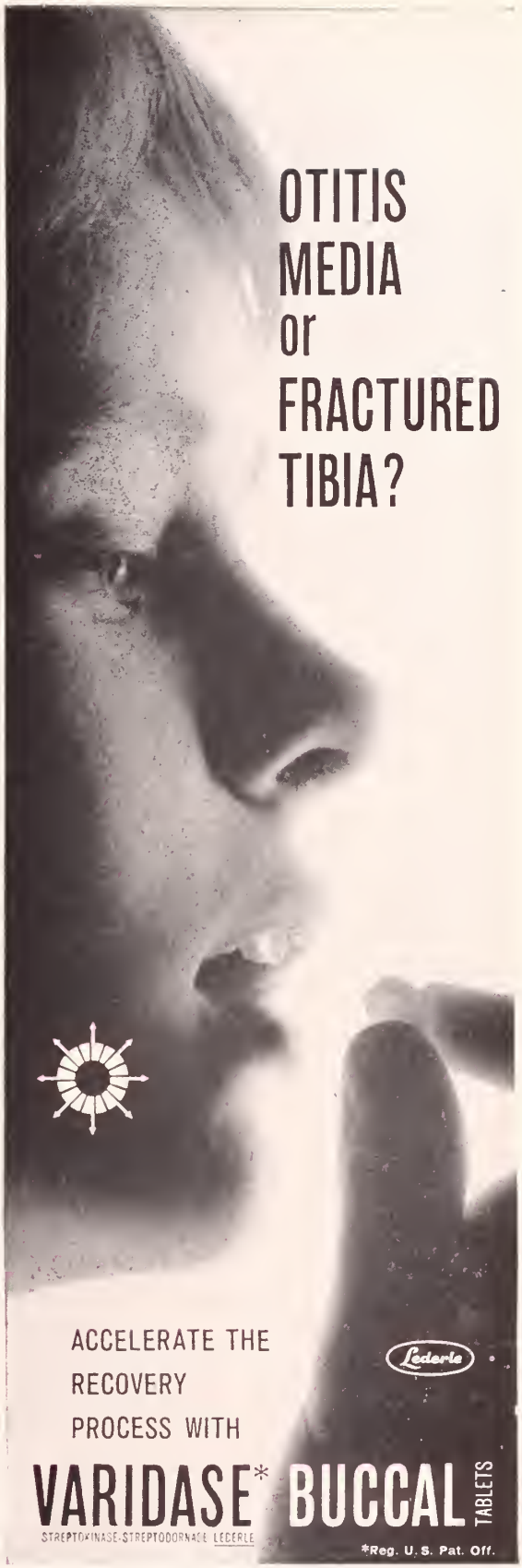
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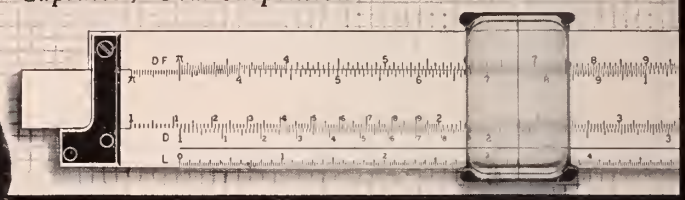
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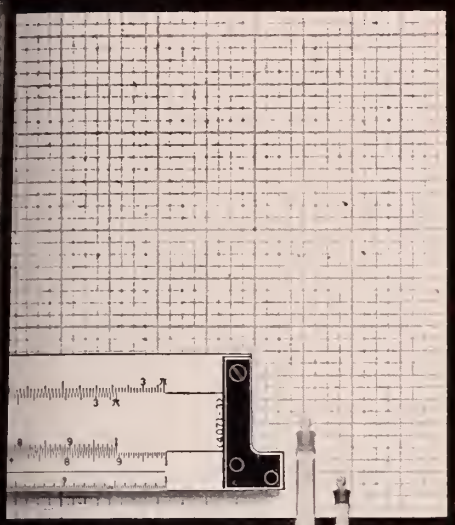




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Conditions treated	No. of Patients	Cured	Improved
ALL INFECTIONS	**558**	**448**	**80**
Respiratory infections	**258**	**208**	**31**
Pharyngitis and/or tonsillitis	65	58	5
Pneumonia	90	66	17
Infectious asthma	44	38	–
Otitis media	31	29	2
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7
Skin and soft tissue infections	**230**	**191**	**38**
Infected wounds, incisions and lacerations	41	33	8
Abscesses	51	43	8
Furunculosis	58	51	6
Acne, pustular	43	28	15
Pyoderma	19	19	–
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1
Genitourinary infections	**28**	**19**	**3**
Acute pyelitis and cystitis	10	8	2
Urethritis with gonorrhea or cystitis	8	8	–
Pyelonephritis	4	1	–
Salpingitis	5	1	1
Pelvic inflammation with endometriosis	1	1	–
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	**42**	**30**	**8**

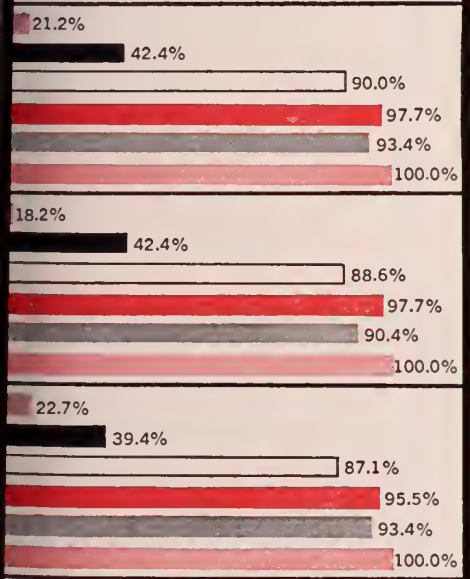




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Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

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Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics. Washington, D. C., Oct. 15-17, 1958.

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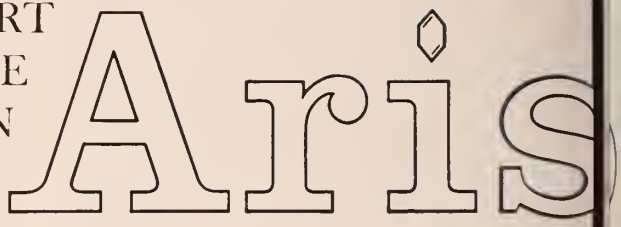
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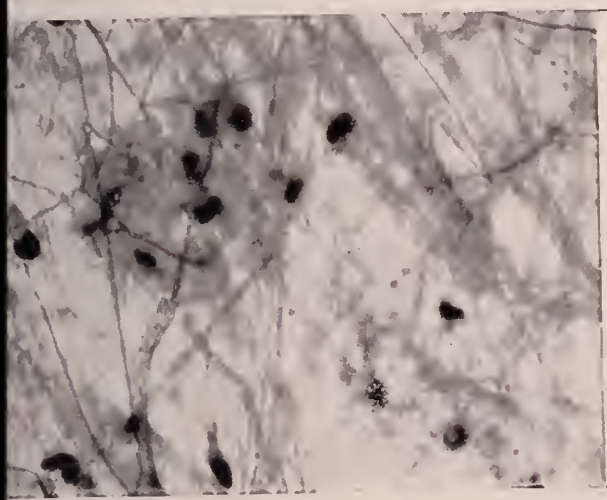
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Number of pregnancies salvaged	46	19
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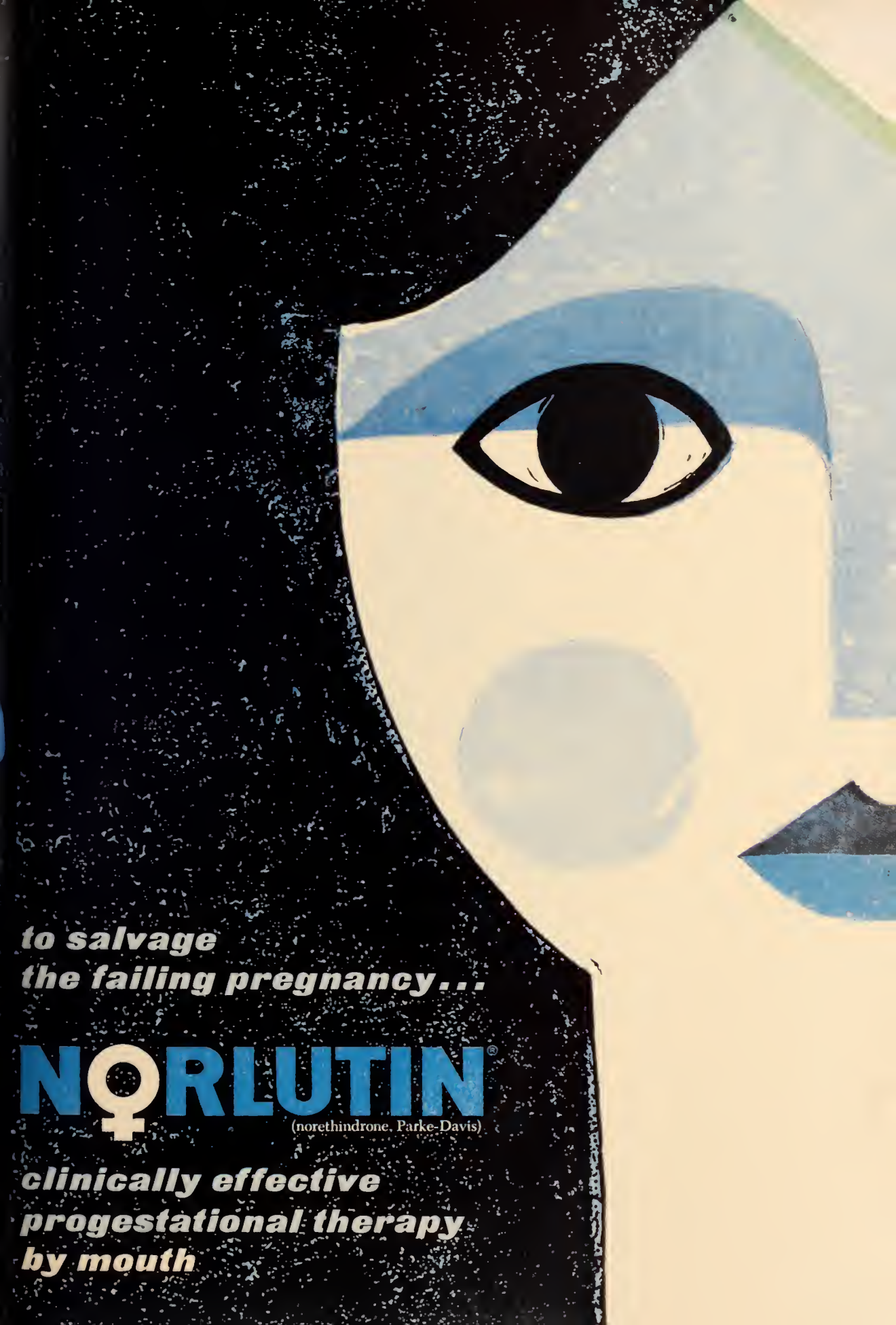
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*C. R. [illegible], J. J. & P. [illegible] A. P. *Ann. New York Acad. Sc.* 71:753

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OF

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CONTENTS—Pages 153 to 222

EDITORIALS— Page

Curing and Caring 153
Euphemisms in Advertising Copy 154
Dr. Fixit 154

ORIGINAL ARTICLES—

Staphylococcal Infections in the Hospital Nursery—Lewis L. Coriell, M.D., Camden, N. J. 155

Carcinoid Syndrome—Thomas Pastras, M.D., Collingswood, N. J. 160

Diagnostic Value of Radiology in Liver Disease—Harry J. Perlberg, Sr., M.D., Harry J. Perlberg, Jr., M.D. and Carroll M. Leevy, M.D., Jersey City, N. J. 163

STATE ACTIVITIES—

Johnson Award 159
Retirement Plan for Physicians Committee 169
Nurses and Intravenous Therapy 169
Society for the Relief of Widows and Orphans 176

ANNOUNCEMENTS 171
OBITUARIES 172
COUNTY SOCIETY REPORTS 173

ANNUAL MEETING PROGRAM—

Daily Schedule 177
Golden Merit Award Ceremony 178
General Session 179
Dinner-Dance 179
Motion Picture Theatre 180
Scientific Section Meetings 181
Nominating Committee 195
House of Delegates 196
Reference Committees 196
Woman's Auxiliary Program 198
Scientific Exhibits 199
Educational Exhibits 203
Technical Exhibits 204

ANNUAL REPORTS OF COUNTY SOCIETIES 210
NTA ABSTRACTS 221

Roster of Officers and Committees, Advertising Page 3A - 6A

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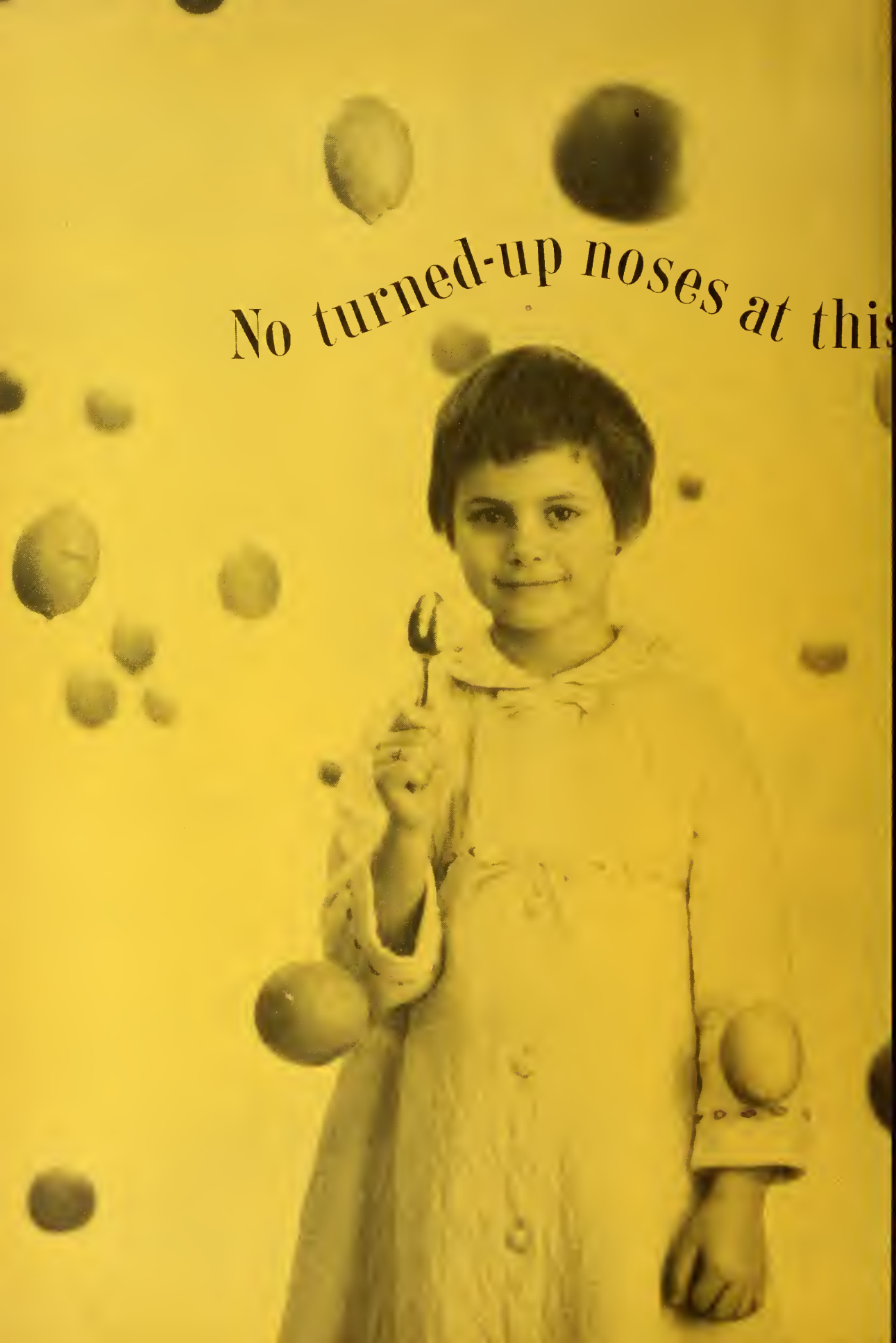
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ERYTHROCIN®

Ethyl Succinate

ORAL SUSPENSION

a new derivative of erythromycin designed especially for children

Never a flavor like this in an antibiotic suspension

A new achievement in pharmaceutical elegance—a ready-mixed stable suspension so sweet and good you can't tell it's "medicine." No bitterness, no unpleasant aftertaste—just pure, sweet citrus flavor.

Never an antibiotic better proved against everyday coccal infections

After millions of prescriptions, an unexcelled safety record. High, peak blood levels within one hour—plus nearly 100% effectiveness against coccal infections. And, unlike broad-spectrum antibiotics, Erythrocin is classed as a bactericidal antibiotic.

INDICATIONS: Against staph-, strep- and pneumococci. Especially useful when patients are allergic to penicillin or other antibiotics. DOSAGE: For children, 30 mg./Kg. per day. Adults, 1 to 2 Gm. daily, depending on severity of infection. SUPPLIED: in 60-cc., pour-lip bottles. Each 5-cc. teaspoonful represents 200-mg. of Erythrocin activity.

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PRINCETON HOSPITAL'S modern approach to long-term nursing care

Merwick, the Elsie Procter Matthews Unit of Princeton Hospital, is a pioneer medical undertaking in the state of New Jersey. Designed specifically for geriatric cases and the chronically ill of all ages (except pediatric cases), it is the first long-term nursing facility in the State directly operated by a general hospital.

The chief purpose of Merwick is to provide an attractive home, complete with all the facilities which make up a well-rounded life within the physical limitations of its guests, while adding the important factors of skilled medical supervision and nursing care.

Designed to house 42 guests, the Unit has the same non-profit status as does the Hospital itself. It functions under the direct supervision of the Hospital administration, with a Hospital Staff physician in charge of medical services.

With nine beautifully landscaped acres surrounding it, Merwick provides a home of rare beauty and quiet and has many unusual facilities available for the comfort and convenience of residents. Brochure available. Rates on request.

For information address: John W. Kauffman, Administrator
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with ample amounts of vitamins—B_1, B_6, B_{12}.

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Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

‡ **ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.**

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CLINICAL BRIEFS
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How can the problem of "postcholecystectomy syndrome" be reduced?

A "routine" operative cholangiogram is now recommended in addition to thorough surgical exploration, reducing the number of cholecystectomized patients later presenting the same symptoms as before the operation.

Source: Vazquez, S. G.: J. Internat. Coll. Surgeons *28*:394, 1957.

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*Hydro*choleresis with DECHOLIN combats bile stasis by flushing the biliary tract with dilute, natural bile...

- corrects excessive bile concentration
- helps to thin gallbladder contents
- benefits patients with chronic cholecystitis, noncalculous cholangitis, and biliary dyskinesia

in functional G.I. distress... **DECHOLIN**® **with BELLADONNA**

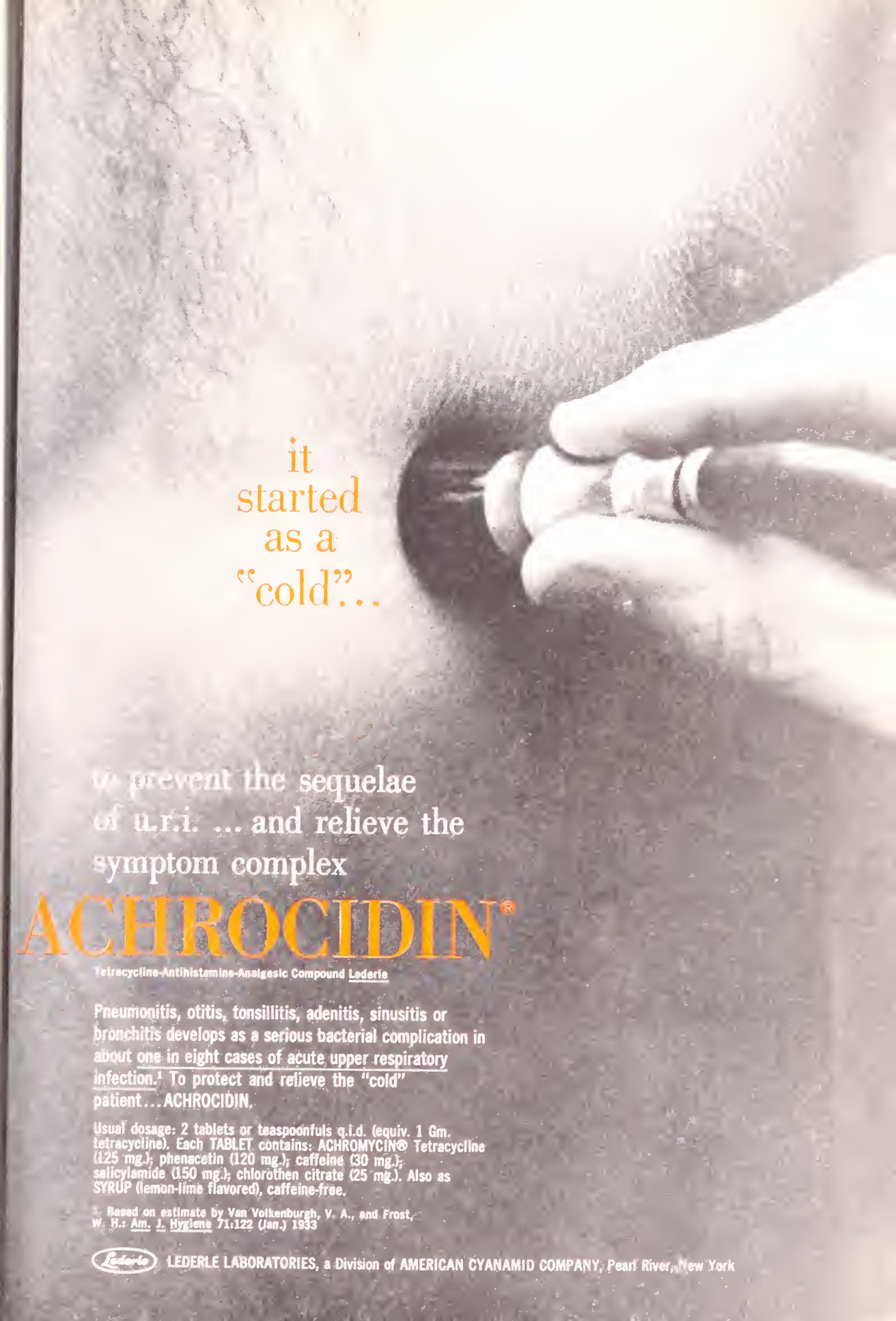
- reliable spasmolysis
- improved liver function

available: DECHOLIN Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.). Bottles of 100, 500 and 1,000; drums of 5,000.

DECHOLIN with Belladonna Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.) and extract of belladonna ⅙ gr. (10 mg.). Bottles of 100 and 500.

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as a
"cold"...
to prevent the sequelae
of u.r.i. ... and relieve the
symptom complex
ACHROCIDIN®
Tetracycline-Antihistamine-Analgesic Compound Lederle
Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or bronchitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.
Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.
1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933
Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

SPONTIN IN SERIOUS

A Special Report from Abbott
to the Medical Profession
on a Year's Clinical Experience
with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections—"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus*, which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases—"Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children—"Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia—"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults—"Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
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10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

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IN 1929

NEW

CREAMALIN

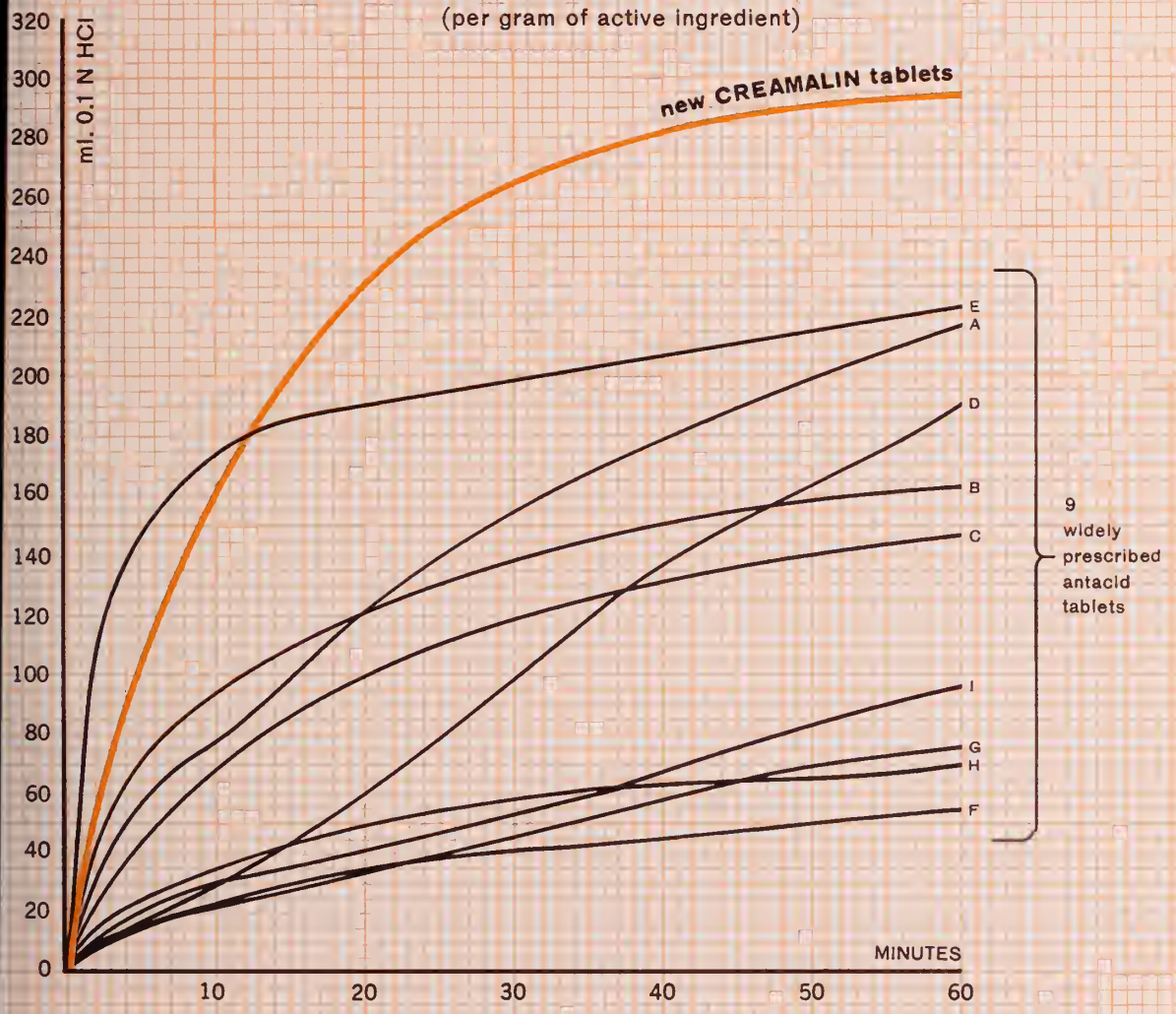
ANTACID TABLETS

Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short polymer dried aluminum hydroxide gel, stabilized with hexitol, with 75 mg. magnesium hydroxide.

1. *Neutralizes acid faster (quicker relief)*
2. *Neutralizes more acid (greater relief)*
3. *Neutralizes acid longer (more lasting relief)*
4. *No constipation · No acid rebound*
5. *More pleasant to take*

REAMALIN NEUTRALIZES MORE ACID FASTER

Quicker Relief · Greater Relief

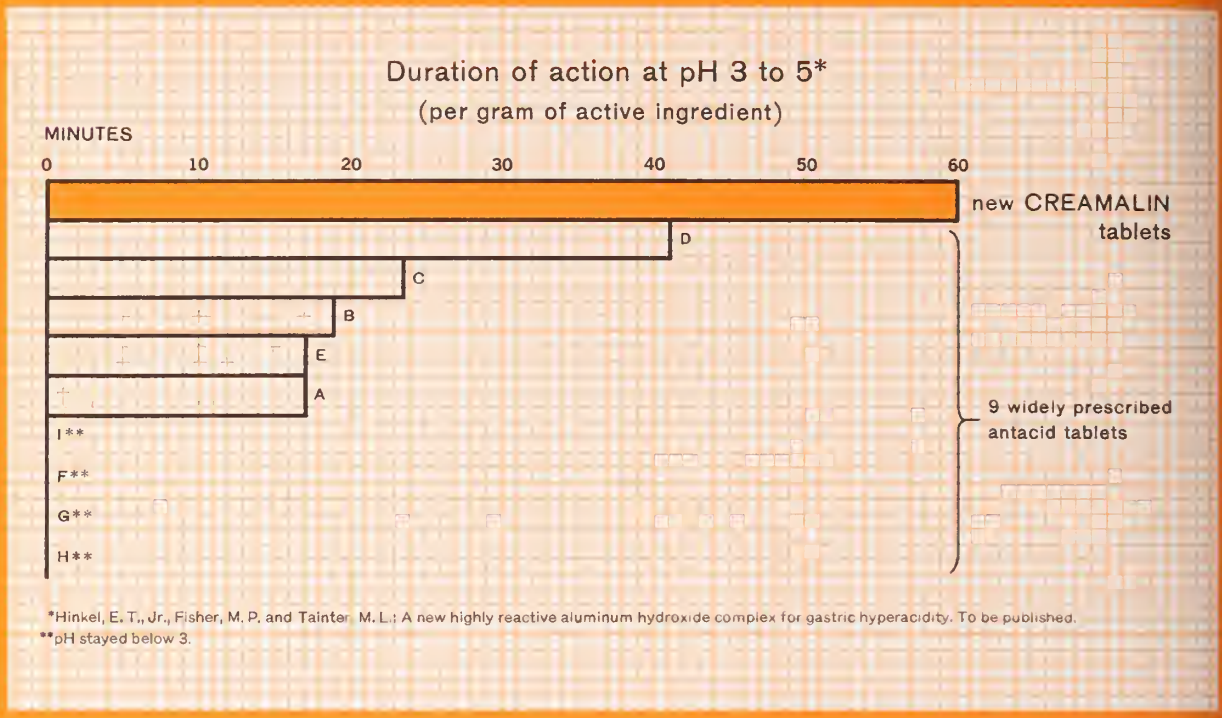


Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain the pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

CREAMALIN NEUTRALIZES MORE ACID LONGER

More Lasting Relief



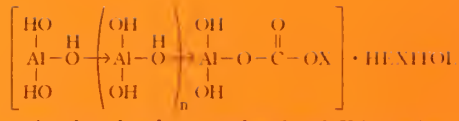
*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.



No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highy palatable, soft, smooth, easy to chew, mint flavored.

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Composition: Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short polymer dried aluminum hydroxide gel, stabilized with hexitol, with 75 mg. magnesium hydroxide.

Adult Dosage: Gastric hyperacidity — 2 to 4 tablets as necessary. Peptic ulcer or gastritis — 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

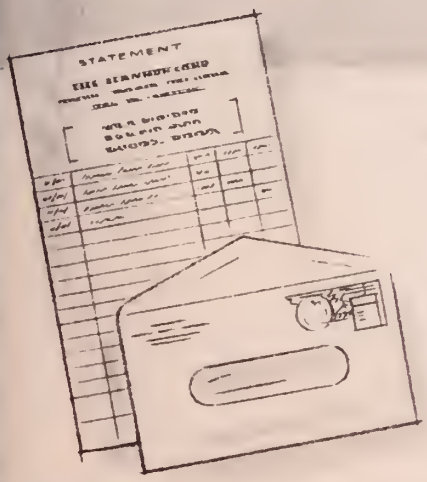
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fruit-punch flavored tablets that will actually "melt in the mouth"



can be chewed like candy



can be crushed and sprinkled on cereal or other food



can be dissolved in water, juice or milk



can be sucked and will dissolve like a lozenge



can be easily swallowed (small tablet size)

VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth.* Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good.* These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B_1, B_2, niacinamide and C, and significant amounts of other essential vitamins.

Each VIGRAN CHEWABLE tablet contains:

Vitamin A	5,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin C	75 mg.
Vitamin B_1	3 mg.
Vitamin B_2	3 mg.
Vitamin B_6	2 mg.
Niacinamide	25 mg.
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Vitamin B_{12}	5 mcg.

Available in Rx-size bottles of 30 and 90.

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IN URTICARIA AND PRUITUS

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HYDROXYZINE PAMOATE



A PSYCHOTHERAPEUTIC ANTIHISTAMINE

(as designated by A.M.A. Council on Drugs, 1958)

SPECIFIC ANTIHISTAMINIC ACTION in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."[1]

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."[2]

PLUS

PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."[3]

RECOMMENDED ORAL DOSAGE: *50 mg. q.i.d. initially; adjust according to individual response.*

VISTARIL Capsules: *25 mg., 50 mg., 100 mg.*

VISTARIL Parenteral Solution: *10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).*



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1. Eisenberg, B. C.: Clinical Medicine *5*:897-904 (July) 1958.
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3. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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Xylocaine HCl solution, the versatile anesthetic for general office surgery, relieves pain promptly and effectively with adequate duration of anesthesia. It is safe and predictable. Local tissue reactions and systemic side effects are rare. Supplied in 20 cc. and 50 cc. vials; 0.5%, 1% and 2% without epinephrine and with epinephrine 1:100,000; also in 2 cc. ampules; 2% without epinephrine and with epinephrine 1:100,000.

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FROM BASIC RESEARCH—BASIC PROGRESS

HYDRO DIURIL*

HYDROCHLOROTHIAZIDE

a new measure of activity



in edema

whenever there is need for diuresis

in hypertension

effective by itself in some patients—always as background medication in any antihypertensive regimen.

summary of clinical information—HYDRODIURIL (HYDROCHLOROTHIAZIDE)

IN EDEMA:

- greater oral effectiveness than with any other class of diuretic agent
- diuretic effectiveness maintained even on prolonged daily administration
- 25 mg. HYDRODIURIL orally is equivalent to 1.6 cc. meralluride I.M.
- has been reported to be effective even in patients who did not respond satisfactorily to other diuretics
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restrictions





HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- similar qualitatively to chlorothiazide but 10 to 12 times more potent
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

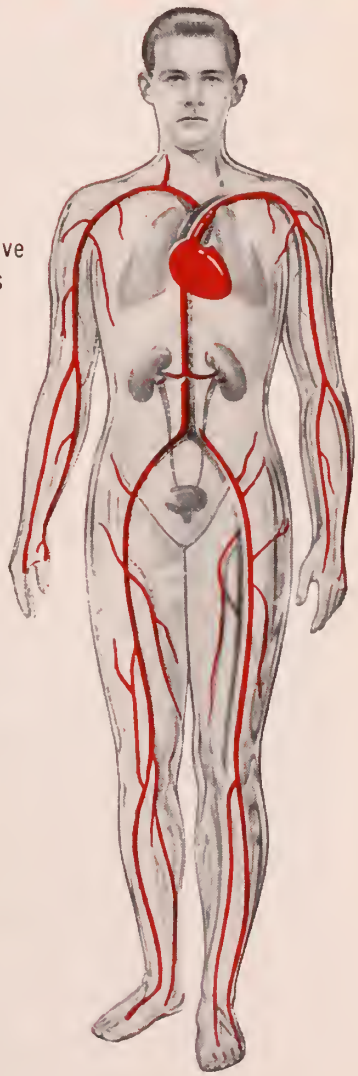
HYDROCHLOROTHIAZIDE

NEW RELEASE

IN HYPERTENSION:

- provides background therapy in any antihypertensive regimen (by itself, HYDRODIURIL adequately controls hypertension in some patients)
- has been reported by some investigators to have a greater antihypertensive effect in some patients than does chlorothiazide at equivalent dose levels
- does not lower blood pressure in normotensives
- markedly potentiates other antihypertensive agents
- reduces dosage requirements for other agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations





HYDRODIURIL*

NEW RELEASE

HYDROCHLOROTHIAZIDE





IS INDICATED IN:

1 Hypertension

2 Congestive heart failure of all degrees of severity

3 Premenstrual tension (edema)

4 Edema of pregnancy

5 Renal edema—nephrosis; nephritis

6 Cirrhosis with ascites

7 Drug-induced edema

8 as adjunctive therapy in the management of obesity complicated by edema

RECOMMENDED DOSAGE RANGE

In **EDEMA:** one to two 50 mg. tablets HYDRODIURIL once or twice a day

In **HYPERTENSION:** one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day. (When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.)

SUPPLIED as 25 mg. and 50 mg. scored tablets, in bottles of 100 and 1000.

PRECAUTIONS:

It is important that dosage be adjusted as frequently as the needs of the individual patient demand.

HYDRODIURIL has shown no adverse effects on renal function and is essentially not nephrotoxic; for this reason it may be used with excellent results even in patients for whom organomercurials are contraindicated because of renal damage. The excretion of potassium is much lower than that of sodium and chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, this potassium loss may be easily replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

Additional information on HYDRODIURIL is available on request.

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MSD MERCK SHARP & DOHME
Division of Merck & Co., INC., Philadelphia 1, Pa.

In the Treatment of Rheumatic Disorders Greater stability of maintenance dosage minimizes risks of hormonal imbalance

In Sterazolidin, the anti-inflammatory actions of prednisone and Butazolidin* are combined to permit lower effective dosage of each. Clinical experience has indicated that patients can be well maintained on this combination over prolonged periods with relatively low, stable dosage levels of each component, thus minimizing the problems arising from excessively high doses of corticosteroids. Other side effects have also been gratifyingly few. Antacid and spasmolytic components are contained in Sterazolidin capsules for the benefit of patients with gastric sensitivity.

Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Detailed information available on request.

*Geigy's trademark for phenylbutazone—Reg. U. S. Pat. Off.

new **Sterazolidin®** Capsules

prednisone-phenylbutazone, Geigy

Geigy Ardsley, New York

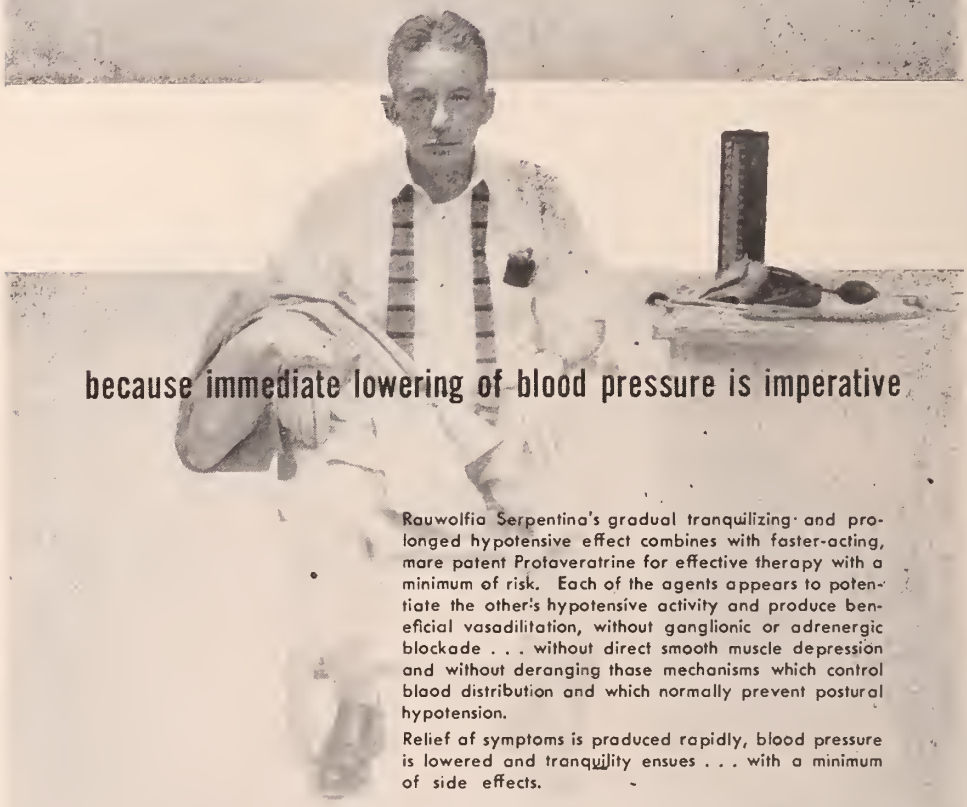


03759

diagnosis: hypertension, moderate to severe

prescribed: **Rauprote***

(Rauwolfia Serpentina and Protoveratrines A & B Combined)



because immediate lowering of blood pressure is imperative

Rauwolfia Serpentina's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protaveratrine for effective therapy with a minimum of risk. Each of the agents appears to potentiate the other's hypotensive activity and produce beneficial vasadilitation, without ganglionic or adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which control blood distribution and which normally prevent postural hypotension.

Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

supplied: in bottles of 100 and 1000 tablets, each containing 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (the chemically standardized alkaloid of Veratrum Alba), or on prescription at leading pharmacies

VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*

PHARMACEUTICALS

*Trade Mark

STOP

running noses and open stuffed noses orally



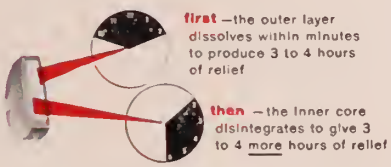
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . . 50 mg.
Pheniramine maleate . . . . . 25 mg.
Pyrilamine maleate . . . . . 25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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The drug that lowered this patient's blood pressure *for the first time without side effects* is now available for your prescription



Singoserp™

(syrosingopine CIBA)

- *a major improvement in rauwolfia*
- *a major advance in antihypertensive therapy*
- *solves the side effects problem in most patients*



◀ Patient P. K. first seen with blood pressure of 220/138 mm. Hg; complained of headache, palpitation, nervous tension, hyperhidrosis. Therapy with chlorothiazide and mecamylamine lowered blood pressure, but patient was troubled by mouth dryness, chest pain, constipation and nocturia (twice a night).



◀ Singoserp was added to the regimen. After 5 months of therapy, pressure ranged between 120/84 and 140/100. One month later chlorothiazide was stopped and patient was maintained on Singoserp alone, 1 mg. b.i.d. Favorable blood pressure continues and he feels well. Since taking Singoserp no side effects reported.

Prescribe Singoserp alone for new patients to lower blood pressure without creating the side effects problem posed by conventional rauwolfia agents.

Prescribe Singoserp for patients now on antihypertensive therapy to lower the dosage requirements of other agents — or even, in some cases, eliminate them altogether.

DOSAGE: Initially, 1 to 2 tablets (1 to 2 mg.) daily.

SUPPLIED: Singoserp *Tablets,* 1 mg. (white, scored); bottles of 100.

SAMPLES available on request. Write to CIBA, Box 277, Summit, N. J. 2/2647

C I B A SUMMIT, N. J.

The Story of Kent

How Lorillard research produced a cigarette with less tars and nicotine than any other leading filter brand



A major research foundation, under Lorillard sponsorship, determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Further research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the superior Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. This is the "MICRONITE" Filter.

The Kent filter is composed of pure cellulose acetate, which is common to the filters used in all leading brands. However, the physical construction of the Kent filter is the exclusive development of Lorillard research, and is different from and superior to all the rest.

Thus, Lorillard research created a filter of ideal purity, with extraordinary ability to eliminate smoke particles...and at the same time, a cigarette of such fine taste that during the past twelve months more smokers changed to Kent than to any other cigarette in America.

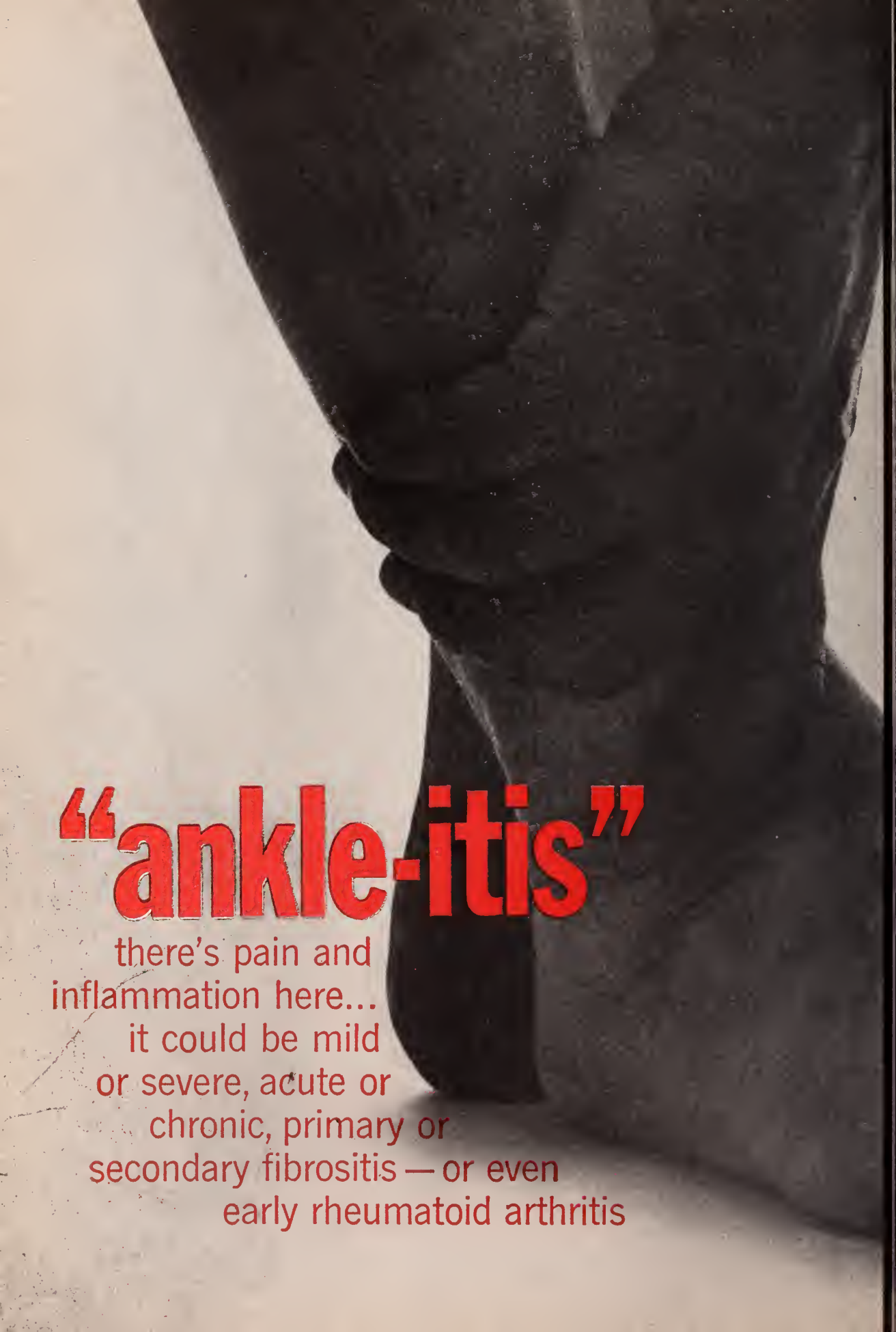
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You get less tars and nicotine in the smoke of Kent than in any other leading filter cigarette in America

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"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

re potent and comprehensive treatment n salicylate alone

ured anti-inflammatory effect of low-dosage ticosteroid[1] . . . additive antirheumatic action of ticosteroid plus salicylate[2-5] brings rapid pain ef; aids restoration of function . . . wide range pplication including the entire fibrositis syn- me as well as early or mild rheumatoid arthritis

re conservative and manageable than full- age corticosteroid therapy—

h less likelihood of treatment-interrupting effects[1-6] . . . reduces possibility of residual ry . . . simple, flexible dosage schedule

RAPY SHOULD BE INDIVIDUALIZED

e conditions: Two or three tablets four times daily. After ed response is obtained, gradually reduce daily dosage then discontinue.

cute or chronic conditions: Initially as above. When sat- tory control is obtained, gradually reduce the daily ge to minimum effective maintenance level. For best lts administer after meals and at bedtime.

autions: Because SIGMAGEN contains prednisone, the e precautions and contraindications observed with this id apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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"WHO, ME, DOCTOR?



I haven't eaten a square meal in months!"

Rabudex-G.R.

CAPSULES

Will help manage:

- The "Nibbler"
- The "Compulsive Eater"
- The "Patient who slyly slips on the pounds"

by

Supplying the more effective 3 to 1 ratio of Dextro to Levo Amphetamine as suggested by Freed and Mizel. (1)

Providing a mild sedative to control nervousness and anxiety (2) often faund in obese potients.

RABUDEX—G.R. capsules are released over a period of 8 to 10 hours with approximately one-third the total dose released in 15-20 minutes and the remoining two-thirds released gradually over the next 8 to 10 hours. As the effects moy last as long as 12 hours, RABUDEX—G.R. should be given early in the day.

Each RABUDEX—G.R. Capsule contains 22.5 mg. dextro amphetamine — 7.5 mg. levo amphetamine plus Butabarbital Sodium 45 mg. as provided by:

Dextro Amphetamine Sulfate	15 mg.
Racemic Amphetamine Sulfate	15 mg.
Butabarbitol Sodium	45 mg.

Available In Bottles Of 100 - 500 - 1,000 Capsules
Sample Supply On Request

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REFERENCES

1. Freed, S. C., and Mizel, M.: Annals of Int. Med., June, 1952.
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Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

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THE HEART DISEASE PATIENT NEEDS RELIEF FROM EMOTIONAL STRESS



ANXIETY INTENSIFIES the physical disorder in heart disease. "The prognosis depends largely on the ability of the physician to control the anxiety factor, as well as the somatic disease."

(Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Cardiol. 1:395, March 1958.)

TRANQUILIZATION WITH MILTOWN enhances recovery from acute cardiac episodes and makes patients more amenable to necessary limitations of activities.

(Waldman, S. and Pelner, L.: Management of anxiety associated with heart disease. Am. Pract. & Digest Treat. 8:1075, July 1957.)

Miltown®

meprobamate (Wallace)

Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules). In combination with a nitrate, for angina pectoris: MILTRATE* (Miltown 200 mg. + PETN 10 mg.).

Miltown causes no adverse effects on heart rate, blood pressure, respiration or other autonomic functions.

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For every topical indication, a Burroughs Wellcome 'SPORIN'...



OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { **LOTION:** Plastic squeeze bottles of 20 cc.
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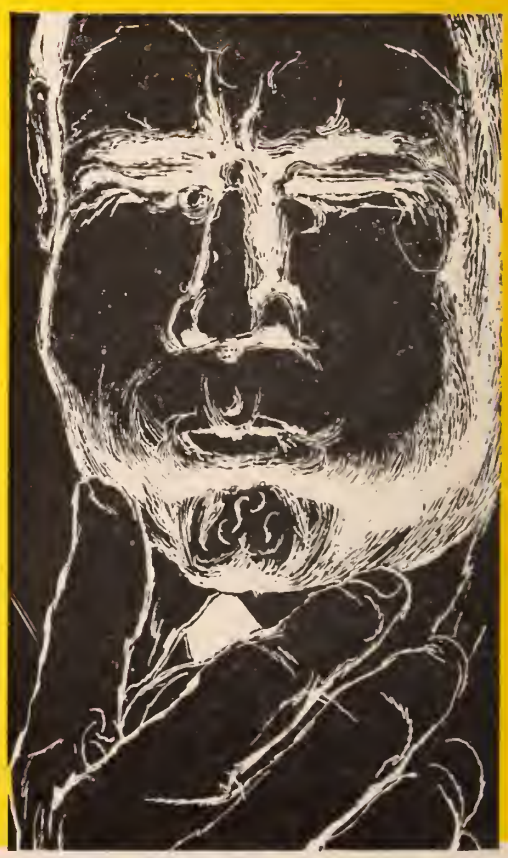
OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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the higher
blood levels of
potassium
penicillin V

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FOR
THOSE
COMMON
BACTERIAL
PROBLEMS



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IN FILMTAB® / IN ORAL SOLUTION
AND IN COMBINATION WITH SULFAS

illin®-VK

(POTASSIUM PENICILLIN V)

INDICATIONS

Against all penicillin-sensitive organisms. When combined with Sulfas, COMPOCILLIN-VK is especially effective in treating mixed infections such as may occur in the respiratory or urinary tract.

DOSAGE

Range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. Children's dosage is determined by body weight. When combined with sulfa triad, range is one Filmtab three times daily to two Filmtabs every four hours.

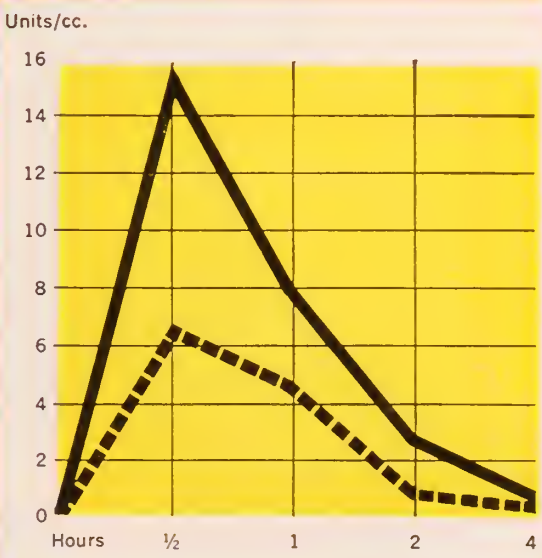
SUPPLIED

COMPOCILLIN-VK Filmtabs: 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100.

COMPOCILLIN-VK Granules for Oral Solution: In 40-cc. and 80-cc. bottles. When reconstituted, each tasty 5-cc. teaspoonful of cherry-flavored solution represents 125 mg. (200,000 units) of potassium penicillin V.

COMPOCILLIN-VK with Sulfas: Each Filmtab contains 125 mg. (200,000 units) of potassium penicillin V and 500 mg. of sulfonamides. At all pharmacies.

Abbott



The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

®FILMTAB—FILM SEALED TABLETS, ABBOTT, PAT. APPLIED FOR.

relieve the tensio



—and control its G.I. sequelae



Patient A.S., age 53.
Intermittent crises of severe pain over 2 year period; hospital management with Sippy regimen provided relief of symptoms; however, symptoms recurred after each sojourn.



PATHIBAMATE *(Tabs. 1 t.i.d. and H.S.)*; prompt relief of symptoms. Radiograph (21 days later) confirms healing of minute lesser curvature gastric ulcer crater.

predictable results in the control of tension and G.I. trauma

Pathibamate®

Meprobamate with PATHILON® Tridihexethyl Chloride* LEDERLE

Used prophylactically in anticipation of periods of emotional stress, or therapeutically to relieve tension and curb hypermotility and hypersecretion. PATHIBAMATE is particularly well-formulated for the control of gastrointestinal disorders.

PATHIBAMATE combines Meprobamate (400 mg.) — the noted tranquilizer-muscle relaxant widely accepted for safe management of tension and anxiety states — and PATHILON (25 mg.) — an extremely well-tolerated anticholinergic, long noted for prompt symptomatic relief based on peripheral atropine-like action with few side effects.

Indications:
Duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis with gastrointestinal symptoms, gastric hypermotility.

Supplied:
Bottles of 100 and 1,000. Each tablet (yellow, ½-scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

Administration and Dosage:
1 tablet three times a day at mealtimes and 2 tablets at bedtime. Adjust dosage to patient response. Contraindicated in glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

Also Available: PATHILON in four forms — *Tablets* of 25 mg., plain (pink) or with *phenobarbital*, 15 mg. (blue);
Parenteral — 10 mg./cc. — 1 cc. ampuls;
Pediatric Drops — 5 mg./cc. — dropper vials of 15 cc.

*PATHILON is now offered as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could interfere with the results of certain thyroid function tests.

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IT IS SO REWARDING AND SO EASY TO SWITCH TO "WIDE SAFETY MARGIN" Gitaligin®

(White's Brand of Amorphous Gitalin)

REWARDING BECAUSE—Gitaligin provides safe, smooth, controlled cardiac therapy.

AVERAGE THERAPEUTIC DOSE IS ONLY 1/3 THE TOXIC DOSE.* The average therapeutic dose of other digitalis preparations is approximately 2/3 the toxic dose.

ELIMINATION IS FASTER than that of digitoxin or digitalis leaf. Therefore, toxicity, should it inadvertently occur, would be of much shorter duration than with either one of these preparations.

EASY BECAUSE—You can easily maintain uninterrupted control of your cardiac patients when you transfer them to Gitaligin by following the simple dosage equivalents listed below.

APPROXIMATE DOSAGE EQUIVALENTS

DIGITALIS PREPARATION	AVERAGE DAILY MAINTENANCE DOSE	GITALIGIN DOSAGE EQUIVALENT
DIGITALIS LEAF	0.1 GM.	0.5 MG.
DIGITOXIN	0.1 MG.	0.5 MG.
DIGOXIN	0.5 MG.	0.5 MG.

SUPPLIED—Gitaligin TABLETS 0.5 mg., bottles of 30 and 100.
Gitaligin INJECTION 2.5 mg. per 5 cc. sterile I.V. solution, boxes of 3 and 12 ampuls.
Gitaligin DROPS with special calibrated dropper, bottles of 30 cc.

*BIBLIOGRAPHY AVAILABLE ON REQUEST.

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in the depressed, unhappy patient

PROMPTLY IMPROVES MOOD

without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.

EFFICACY AND SAFETY CONFIRMED IN OVER 3,000 DOCUMENTED CASE HISTORIES.[1, 2, 3]



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each light-pink, scored tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

▲Deprol▲†

References:

1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

®WALLACE LABORATORIES, *New Brunswick, N. J.*

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OBSTETRICAL — GYNECOLOGICAL

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FOR THE MEDICAL PROFESSION

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Convenient information for physicians starting diabetic patients on

DIABINESE

simple once-a-day dosage in practice

During the initial control period, the patient should check his urine at frequent intervals, and report at least once weekly for review of symptoms, physical examination, urine and/or blood examination for glucose.

The New Patient *(no previous antidiabetic therapy)*

1. Initial daily dose 500 mg. (2 tablets of 250 mg. each) with breakfast.

2. In elderly patients, initial dose 250 mg. (1 tablet) daily.

3. CONTROL PERIOD

(a) If blood sugar reaches normal levels after three to seven days, or if glycosuria disappears, lower daily dose of 500 mg. to a level between 250 mg. (1 tablet) and 375 mg. (1½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage may be reduced to as low as 100 mg.

(b) If hyperglycemia or glycosuria persists or develops, increase the daily dose from 500 mg. to 625 mg. (2½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage should be increased from 250 mg. according to patient response.

(c) Continue weekly adjustments during first month of therapy until maintenance dose has been established. Adjustments below 250 mg. daily are best made in steps of 100 mg. (one 100 mg. tablet). The maintenance dose may occasionally be as low as 100 mg. (one 100 mg. tablet daily) or, rarely, as high as 1.0 Gm. (four 250 mg. tablets) daily. Do not exceed daily dose of 1.0 Gm.

Transfer of Patient from Insulin

1. If patient is taking 40 or less units of insulin daily and gives no history of severe or "brittle" diabetic response, discontinue insulin and replace with DIABINESE as in The New Patient.

2. Complete control period as for The New Patient. Priming ("loading") doses should not be used.

3. If patient is taking more than 40 units of insulin daily, or shows evidence of severe or brittle diabetes, reduce insulin dose by 50 per cent and initiate DIABINESE therapy as for The New Patient. Further reduction of insulin dosage depends on patient response.

Transfer of Patient from Other Oral Medication

Where less than satisfactory control has been achieved with other oral medication, or where a change to once-a-day dosage is desired, DIABINESE may be successfully substituted. Such a transfer may be made by discontinuing previous oral medication, substituting DIABINESE, and continuing control period as for The New Patient. Avoid priming doses.

The clinical safety of DIABINESE has been established by more than two years' trial. By adherence to the above dosage schedule, side effects of DIABINESE will generally be infrequent, mild, and transient.

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DIABINESE®

brand of chlorpropamide

once-a-day dosage

THE MOST EFFECTIVE ORAL ANTIDIABETIC AVAILABLE

SUPPLIED. *Tablets*, 250 mg., bottles of 60 and 250, white, scored. 100 mg., bottles of 100, white, scored.

Science for the world's well-being *Pfizer* PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, N. Y.



MENNEN BABY MAGIC
Actually prevents
and heals diaper rash!

A THREE-HANDED ASSISTANT...



MENNEN BABY OIL
A better, safer cleanser
than soap!

IN THE FIGHT AGAINST DIAPER RASH!



MENNEN BABY POWDER
It's wet-resistant; protects
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poleon exhibited ulcer symptoms through most of adult life, yet he scorned medication for his ever- ting "spasms of nervous origin." He ignored his irmities with violent naïveté despite an intense in- est in medical science. Thus, the classic hand-in- at pose may have been the result of his paroxysms gastric pain that sliced "like the stab of a penknife."

hen your patient is besieged with an ulcer, obins provides you with an armamentarium fficient to repel it.

ontal assault —If your tactics dictate Local ction, try ROBALATE,® which is dihydroxy uminum aminoacetate (0.5 Gm. per tablet or cc.), an antacid of definitely superior efficacy.

ncirclement — If you prefer to approach the lcer Systemically, prescribe ONNATAL,® the anticholinergic-antispasmodic-sedative with the tim tested *natural* belladonna alkaloids and phen barbital, a veteran campaigner without pee FORMULA: hyoscyamine sulfate, 0.1037 mg atropine sulfate, 0.0194 mg.; hyoscine hydr bromide, 0.0065 mg.; and phenobarbital (1 gr.), 16.2 mg.

multi-pronged attack — If you relish tl strategy of combining antacid and antispasmo ic-anticholinergic effects, use DONNALATE It combines one-half of a DONNATAL tabl with one ROBALATE, ideal allies for compr hensive ulcer therapy.

Victory will be yours.

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CONGRATULATIONS

to

THE MEDICAL SOCIETY OF NEW JERSEY

on the occasion of its

193rd ANNUAL MEETING



Public Service Electric and Gas Company

NOW many more hypertensive patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

Except for one case of mild blood-pressure elevation (150/90) **no hypertension was seen in any of 1500 patients**† as a result of treatment with DECADRON—the new and, on a milligram basis, most potent of all corticosteroids. **Hypertension induced by other steroids diminished or disappeared.**

Thus with DECADRON, hypertension no longer appears to be a contraindication to successful corticosteroid therapy. And the dramatic therapeutic impact of DECADRON was virtually unmarred by diabetogenic or psychic reactions . . . Cushingoid effects were fewer and milder . . . and there were no new or "peculiar" side effects. Moreover, DECADRON helped restore a "natural" sense of well-being.

†Analysis of clinical reports.

Decadron*

DEXAMETHASONE

treats more patients more effectively

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PRONOUNCED TAY-O

Tao*

(triacetyloleandomycin)

Capsules / Oral Suspension

** designed for superior control of common Gram-pos infections*

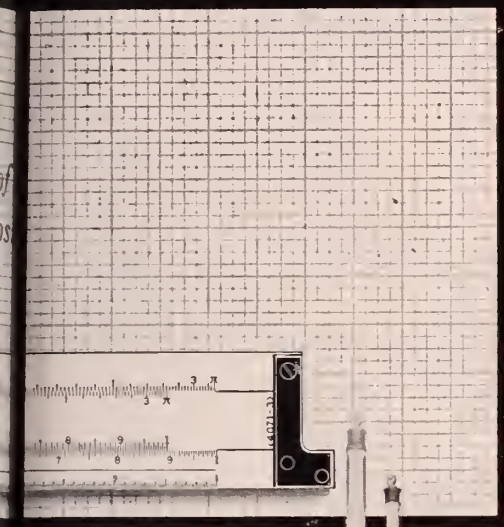


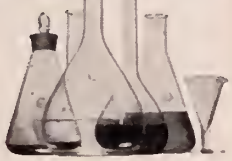


in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Fa
ALL INFECTIONS	**558**	**448**	**80**	
Respiratory infections	**258**	**208**	**31**	
Pharyngitis and/or tonsillitis	65	58	5	
Pneumonia	90	66	17	
Infectious asthma	44	38	–	
Otitis media	31	29	2	
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	
Skin and soft tissue infections	**230**	**191**	**38**	
Infected wounds, incisions and lacerations	41	33	8	
Abscesses	51	43	8	
Furunculosis	58	51	6	
Acne, pustular	43	28	15	
Pyoderma	19	19	–	
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	
Genitourinary infections	**28**	**19**	**3**	6
Acute pyelitis and cystitis	10	8	2	
Urethritis with gonorrhea or cystitis	8	8	–	
Pyelonephritis	4	1	–	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	–	
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

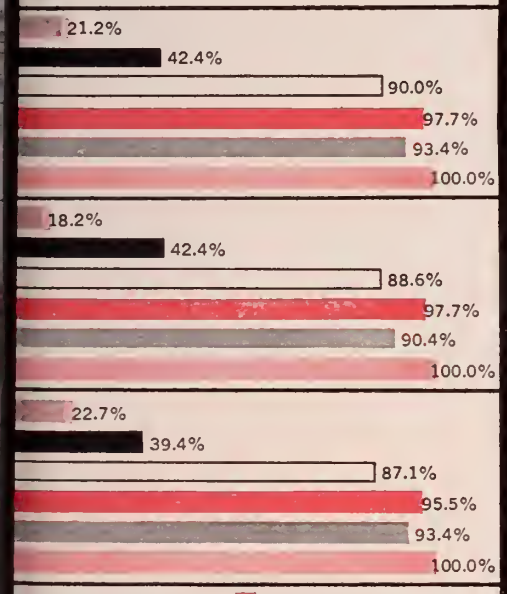




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oratory:

90% effective
nst resistant staph

RATIVE TESTS BY THREE METHODS
TUBE DILUTION, CYLINDER PLATE)
STAPHYLOCOCCI[9]



ibiotic A 2-10 units
ibiotic B 5-30 mcg.
ibiotic C 5-30 mcg.
TAO 2-15 mcg.
Antibiotic D 2-15 mcg.
Antibiotic E 5-30 mcg.

tage of organisms inhibited by the range of
ntrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics. Washington, D. C., Oct. 15-17, 1958.

TAO dosage forms—
for specific clinical situations

TAO Pediatric Drops

For children—flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers—5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

TAO-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

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For dual control of Gram-positive and Gram-negative infections.

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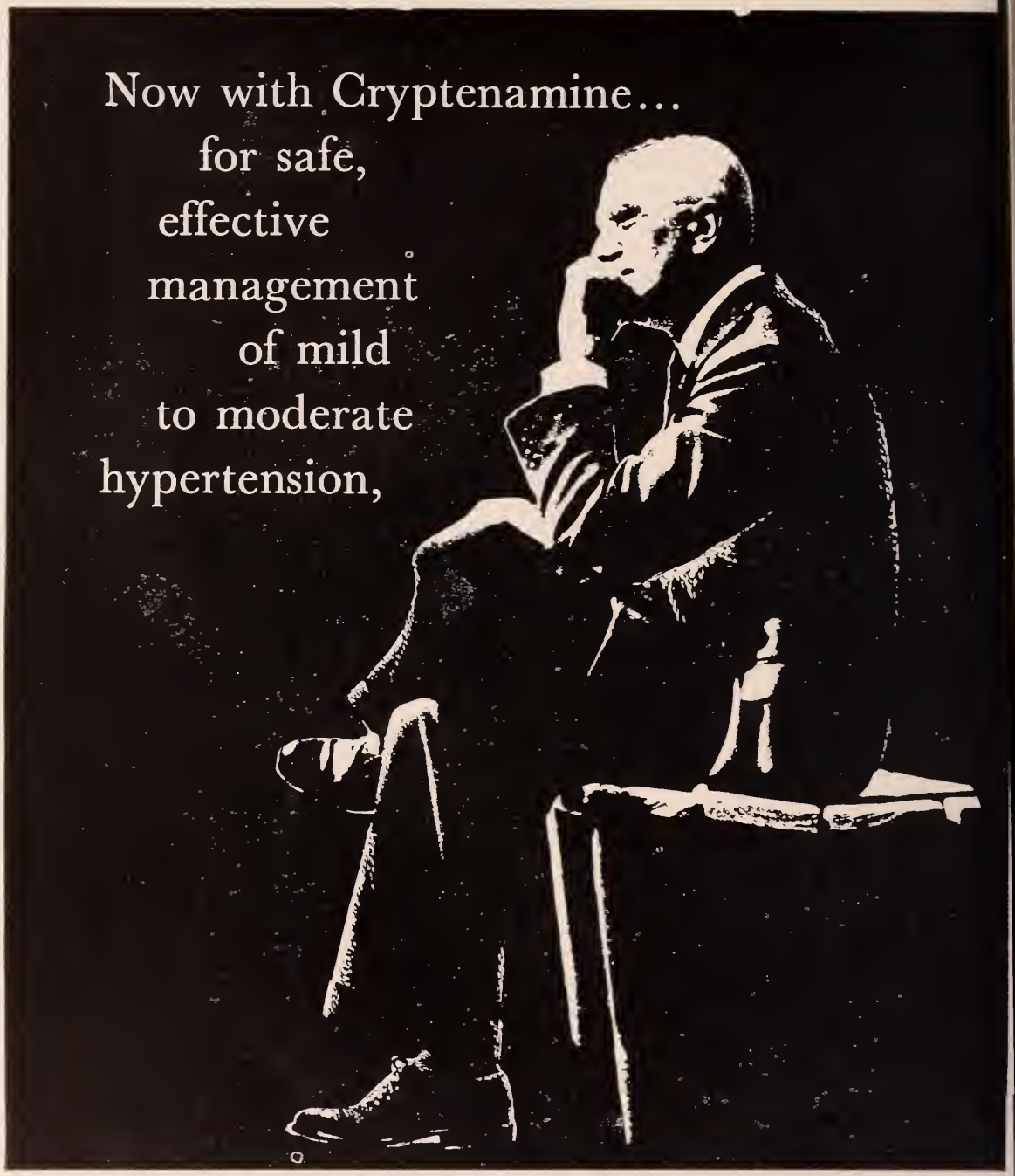
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Veratrite effectively reduces blood pressure through action on the sympathetic nervous system, without detriment to the cardiac output.

Each VERATRITE tabule contains:

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To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

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†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

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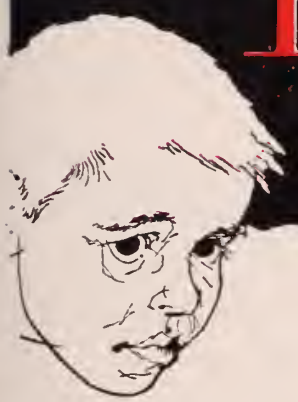
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For Emotionally Disturbed Children

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Anti-Depressant



Do Not confuse it with tranquilizers

'Deaner' must not be confused with tranquilizing or sedative drugs which may aggravate depression. On the contrary, 'Deaner' is often used to counteract drug-induced depression.

'Deaner' is valuable as an emotional normalizer in many situations other than depression, such as behavior problems with agitation. Nor should 'Deaner' be considered an ordinary stimulant. Its gentle action differs from that of other stimulants in that it leads to increased useful energy and alertness without the undesirable side effects of the amphetamine-like drugs.

Deaner a totally new molecule, offers a new type of alleviation in depression, fatigue states and many other emotional disturbances. Its physiologic effectiveness as a safe central nervous system stimulant is attributed to its activity as a probable precursor to acetylcholine.

Deaner leads to better ability to concentrate, increased daytime energy, sounder sleep (with less sleep needed), and a more affable mood.

Deaner acts gently, gradually, and its effects are prolonged... without causing hyperirritability... without loss of appetite... without elevating blood pressure or heart rate... without sudden letdown on discontinuance.

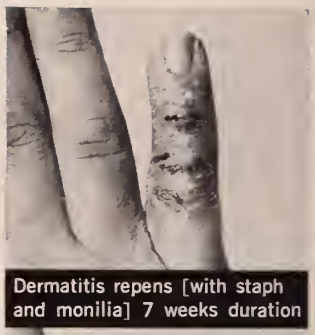
Deaner is valuable in the treatment of children, especially those whose performance is impaired by behavior problems, whose attention span is too short, and who are emotionally unstable, unpredictable, and unadaptable.

Dosage for children: Initially ½ to 1 tablet in the morning. Maintenance dose ½ to 3 tablets. Full benefits may require two weeks or more of therapy. Supplied in scored tablets containing 25 mg. of 2-dimethylaminoethanol as the p-acetamidobenzoic acid salt. Available in bottles of 100.

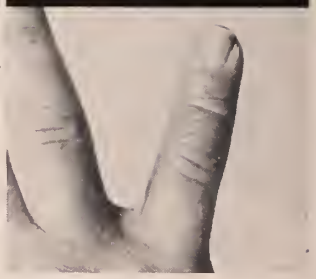
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new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions



Dermatitis repens [with staph and monilia] 7 weeks duration

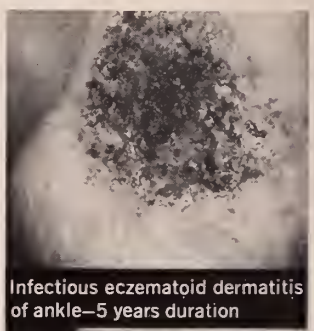


Cleared in 5 days

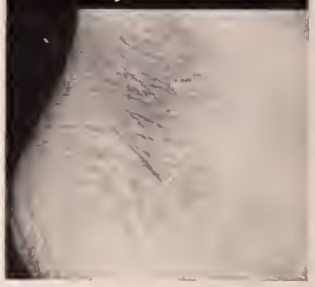
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antipruritic / anti-inflammatory / antibacterial / antifungal



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] — neomycin and gramicidin for powerful antibacterial action[7] — and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

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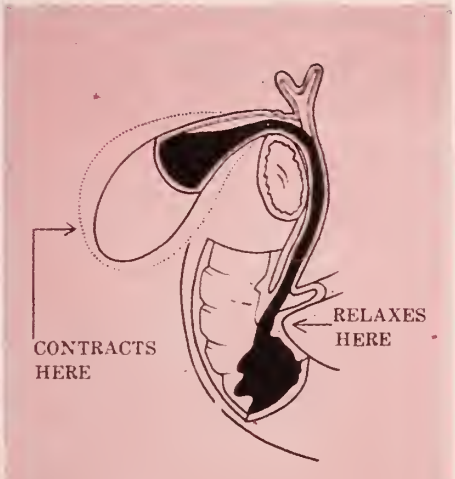
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1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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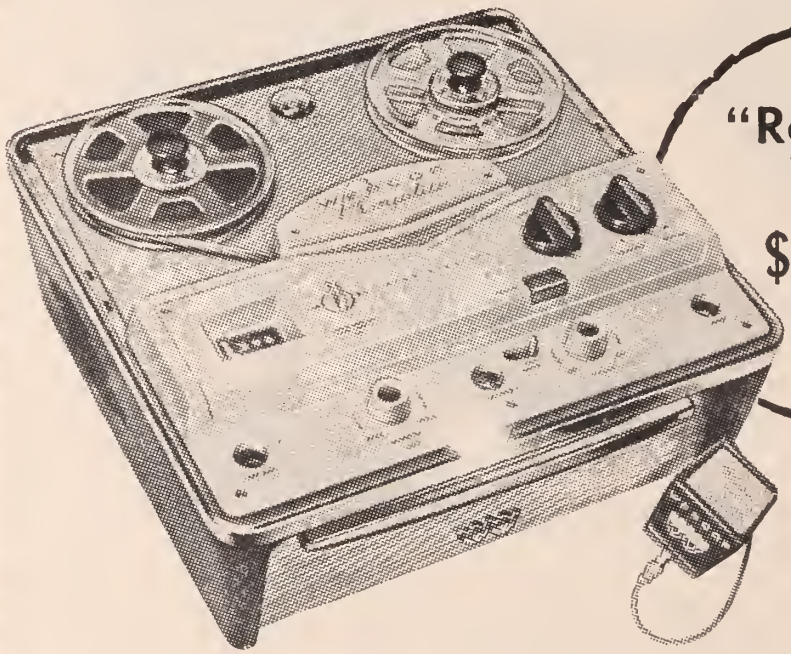
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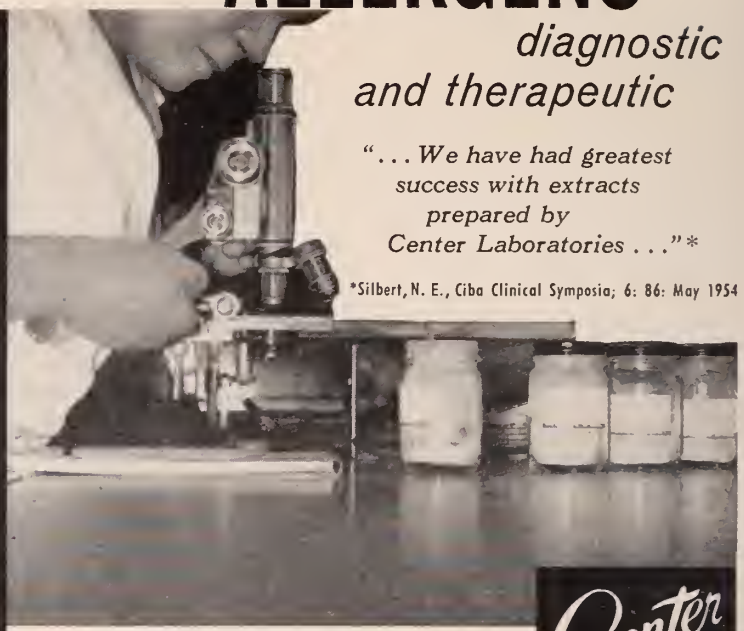
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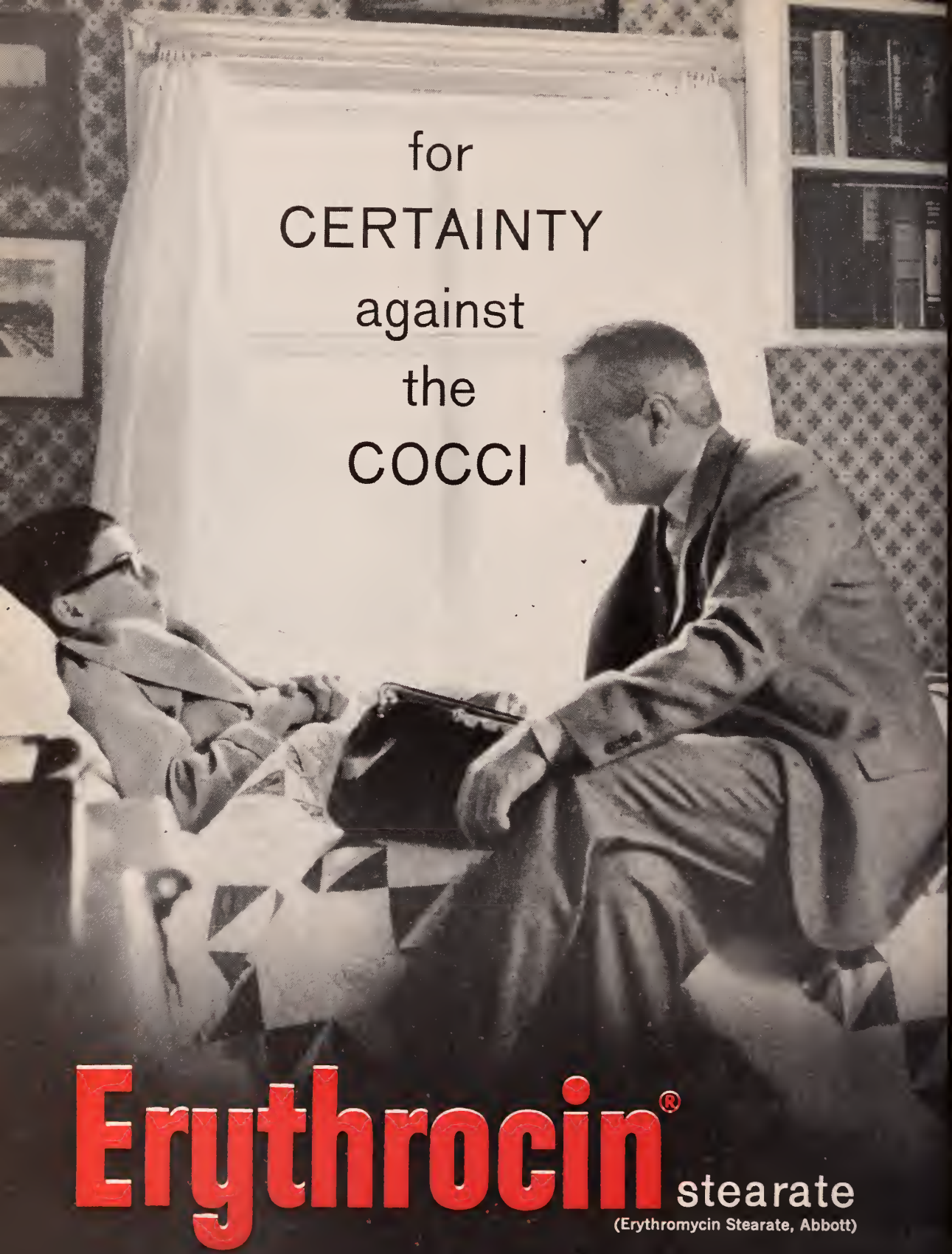
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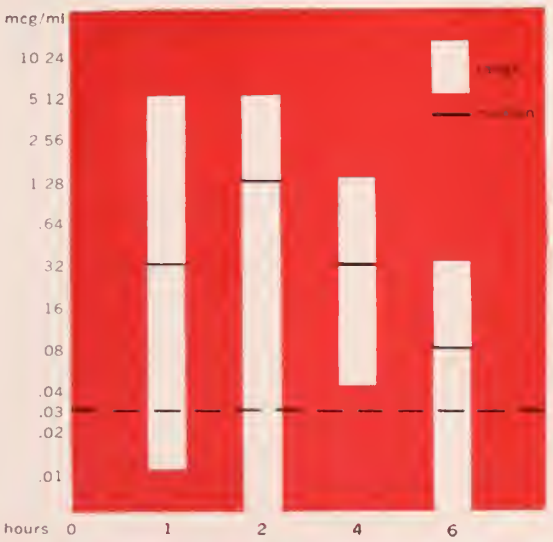
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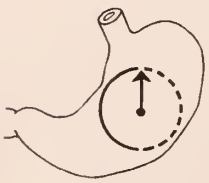
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THE JOURNAL
OF
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Editorials • • •

Curing and Caring

As the curable diseases are brought under control, the "incurable" ones loom larger and larger in our practices. At this point, the doctor's mission shifts from cure to care. Etymologically the words are identical: both stem from the Latin *cura*, care. But that single vowel—that shift from the *u* of "cure" to the *a* of "care" makes a world of difference to too many doctors. The physician can do much to make comfortable the patient with chronic, nontreatable illness. But many of us are embarrassed in the presence of such a patient. He is a living repudiation of our mission—or so we think. We would like to transfer responsibility to the family, to the visiting nurse, to a social agency, to a home for the chronically ill—anything to get the untreatable patient off our own active list.

But there is still need for compassion and for care. There are still technics for relieving pain and disability. There is still the cheer of solace. And there is always that last blessing in Pandora's box: hope. There are patients who have outlived the doctors who have pronounced death sentences.

To care for patients we have to care for people. The word "care" here has a double meaning. In the first clause it meant "manage" in the second clause it meant "like people —or feel comfortable with them." But this is no idle pun: it is the stuff of healing art. Every medical student is told: treat patients not diseases; treat sick people not pathologic lesions. The advice is well meant but is often meaningless until it springs into action. Anybody can handle a self-limiting disease. But it takes a real doctor to keep burning the spark of hope and to keep comfortable the patient with permanent illness. Let us be worthy of that challenge.

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Euphemisms in Advertising Copy

The mailman, the other day, brought in an advertisement for a new drug to be used for constipation. The copywriter apparently anxious to avoid that ugly word referred to it as "fecal frustration."

Thus, there has been opened up a new field of semantic ingenuity. Instead of treating baldness, why not treat smoothness of the scalp? One might advertise a new astringent for diarrhea by saying: "If it never rains but it pours, use sweet tincture of chalk." The makers of anti-hemorrhoidal ointments could advertise: "For the bright spot of the day, use Pilosoothe."

We leave it to our readers to find a euphemism for impotence.

Dr. Fixit

In a natural and commendable desire to recapture the place of the old family medical retainer, many of us indicate that we are available for consultation on all domestic, familial and personal problems. One doctor told us that in one afternoon he was consulted by (1) a mother who wanted him to give her teenage daughter advice on how to conduct herself (protect herself?) on a date; (2) a man who feared that his wife was "spoiling" the children by indulging them and who wanted the doctor to give the wife a good talking-to; and (3) by a couple who were alarmed because their son wanted to marry a girl of another faith, and who wanted the doctor to give him a lecture on the evils of mixed marriage.

It used to be the pride of family doctors that they could gracefully serve as marriage counsellors, father confessors, vocational guides, travellers' aide helpers, vacation planners, and experts on bringing up children. This omnipotence has been destroyed partly by the rise of specialization in medicine so that it would take an entire hospital staff to cover all of the areas on which the old-fashioned family doctor was an expert. Another factor in the diminution of the doctor's role as general advice-giver has been the development of other professions in this field such as marriage counselling, vocational guidance and the like. Some physicians, alarmed at their being reduced to serving either as writers of prescription blanks, feeding stations for specialists or filler-outers of insurance forms, feel that they can recapture the old glory by being available to handle all of the familial and vocational problems of all of their patients.

One doctor recently got into an argument with the motor vehicle department over whether a highly accident-prone man should have his driving license restored. We know of doctors who plunge in cheerfully to try to handle problems of alcoholism and drug addiction, which have defied far greater experts. Many physicians are enchanted by the philosophy: "the doctor knows best." They then undertake to pontificate on all phases of life, love and labor.

Since we are all busy enough as it is, it would seem rather gratuitous to seek opportunities to play the role of Dr. Fixit. This produces a certain brief satisfaction in the doctor. But in the long run it impairs his dignity and status in the community as well as his usefulness to patients. We doctors are generally very strong on shielding people's privacy and also on protecting individualism. Under the circumstances, we should be careful not to invade the lives of others nor even to relieve other people from the burden of making their own decisions and their own mistakes.

LEWIS L. CORIELL, M.D.
Camden

Staphylococcal Infections in the Hospital Nursery*

The introduction of antibiotics has lulled us into a feeling of security with respect to infections in hospitals. This paper reminds us that the danger still exists and suggests effective measures of control.

IN SEVERAL excellent scientific reviews[1-8] as well as in the lay press the problem of antibiotic resistant staphylococci has been well documented and generally deplored. This review will survey from a clinical standpoint the current problems presented and condense suggestions thought to be helpful in the diagnosis, treatment, and prevention of these infections.

THE PROBLEMS

SPORADIC cases of staphylococcal infections always have been and probably always will be present. The occurrence of epidemics of staphylococcal infections in hospitals is the frightening problem which now has everyone concerned. The most prevalent manifestations may be grouped as follows:

Surgery: Wound suppuration, pyemia, septicemia, pneumonia.
Newborn Nursery: Pyodermia, impetigo, mastitis, conjunctivitis, gastroenteritis, pneumonia, empyema.
Nursing Mother: Mastitis.
Family and Hospital Contacts: Pyodermia.

Staphylococcal pneumonia in some hospitals is now a significant cause of death in newborn infants, surgical patients, patients with influenza, and in patients with burns and with debilitating diseases such as asthma, coronary occlusion and diabetes. Many of these infections are acquired in the hospital.

Omitted from this list are such non-epidemic or uncommon conditions as acute hematogenous osteomyelitis, food poisoning, acute pyelonephritis, acute endocarditis, and meningitis caused by staphylococci.

HISTORY

AS REVIEWED by Ravenholt[1] staphylococcal disease is as old as recorded medical history. Epidemics of pemphigus neonatorum were described as early as 1773 and periodically since then. The hazard to mother and infant following delivery in the hospital was clearly shown by Semmelweis.[9] For centuries suppuration was usual following surgery. This morbidity improved with the advent of antiseptic surgery and was reduced to less than

*Read at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 20, 1958. Dr. Coriell is Medical Director of the Camden Municipal Hospital.

Supported in part by grant from the Upjohn Company.

5 or 10 per cent of cases by the use of aseptic technics.

Epidemics of pyodermia (*i.e.*, boils, carbuncles, pustules, whitlows, paronychias) are not new. Hunt,[10] for example, described such a "furunculoid epidemic" which lasted in England and Wales from 1840 to 1852.

In the past, as at present, outbreaks of staphylococcal infections were associated with hospitals. Even before the days of Pasteur and Lister careful observers noted that the number of infected wounds was proportional to the crowding and poor hygiene of the patients.[11]

It is common knowledge today that the high suppuration rate in hospitals in the 19th century was in large part caused by direct transfer of infection from patient to patient in crowded wards or indirectly through the medium of the attendants, instruments, dressing carts, hands, bedding, flies or dust, plus the lack of soap and water for bathing and personal cleanliness. If we are again experiencing some of the same problems of hospital infections it seems logical to suspect that some of these same factors are responsible. How can this be true with all our knowledge of bacteriology, hygiene and sanitation?

ALMOST a generation has passed since the introduction of penicillin. At first it was nearly 100 per cent effective for staphylococcal infections even though some strains were moderately resistant. A combination of penicillin with streptomycin was effective against these resistant organisms and as other antibiotics were developed they were widely used alone or in combination. Dramatic as was the therapeutic use of antibiotics their use prophylactically in patients at risk of infection was even more impressive. Pyogenic complications were thereby avoided in medical patients, pyodermias were prevented in nurseries, and pretreatment of surgical patients eliminated postoperative infection and permitted procedures not possible before.

For these reasons most hospitalized patients received penicillin and other antibiotics. Over the years a number of staphylococcal strains became adapted to the constant presence of antibiotics and some of these resistant strains which also have invasive and pathogenic properties are now causing disease patterns like those which occurred before the antibiotic era.

A generation of medical personnel has learned to lean too heavily on the magic of penicillin, perhaps with some concomitant relaxation of hygienic and aseptic technics.

Why have recent epidemics of staphylococcal infections occurred almost exclusively in hospitals? This was true in the distant past as well as at present. One reason is that staphylococci are opportunists which cause disease when the natural defensive mechanisms are impaired. People with lowered natural defensive mechanisms collect in hospitals, *i.e.*, the very young, the ill, the wounded, the very old, the infected and injured, and those to undergo surgery. If these patients are exposed to strains of resistant staphylococci through septic technics, inadequate isolation, carriers of staphylococci among the personnel, and unnecessary use of antibiotic procedures, the stage is set for endemic staphylococcal infections as well as more explosive outbreaks when many predisposing factors occur simultaneously.

It should be added that the "80-81" strain of staphylococci is now well seeded in the population outside hospitals.[5] In a recent survey of well children attending rheumatic fever prophylactic clinics in Philadelphia, 12 of 70 (or 17 per cent) were harboring "80-81" staphylococci in their anterior nares.

NEWBORN INFECTIONS

IN NINE epidemics among newborn infants Wentworth[2] observed a similar sequence of pyodermia, mastitis, and pneumonia in the infants, breast abscesses in the mother, and boils, carbuncles and abscesses in the family contacts after the infant went home. He also cites other epidemics in newborn nurseries produced by the "epidemic strain" of staphylococcus of bacteriophage type 42B/44A/47C/-52/80/81. Infection usually seemed to originate in the nursery. For example, in one representative epidemic 23 of 90 infants developed pyodermia while in the nursery. And 48 other infants were shown to be carriers of the same

type staphylococcus after they went home. Eighty per cent of these babies subsequently developed suppurative lesions. Over a 3 to 6 months observation period three-fourths of the mothers and one-third of the fathers and siblings in these homes became nasopharyngeal carriers. Clinical disease occurred in 40 per cent of these mothers and fathers and in 70 per cent of the carrier siblings.

The clinical signs and symptoms of staphylococcic infection in a newborn nursery may be subtle at first or the course may be rapid and fatal. Loss of appetite, failure to nurse and weight loss may be the only signs. Fever and leukocytosis may not be present early. Four grades of severity may be observed in newborn infants: (1) tiny yellow vesicles which do not spread, found chiefly in the scalp, neck and folds of the axilla; (2) bullous impetigo; (3) localized infection and edema of the skin without vesiculation, and (4) Ritter's disease with generalized erythema of the skin accompanied by loss of epidermis whenever pressure is applied. Localized pus and abscess formation are uncommon in the first week of life but common in older infants, including breast abscess, pneumonia, empyema, pustules, osteomyelitis, pyemia with multiple abscess formation.

SOURCE OF INFECTION

HEALTHY carriers of the epidemic strain among the nursery personnel have been demonstrated repeatedly and must be regarded as one of the most important sources for nursery infection. Crowding, inhalation of infected dust from sheets and blankets, use of common dressing tables, failure to wash hands between babies, infected boric acid, skin lotions or oil and other solutions are some of the common mechanisms by which organisms are passed to the babies.

The importance of good housekeeping, isolation and nursing technic has been demonstrated by controlling certain outbreaks without removing the carrier from the nursery. Another observation which indicates the importance of nursery technic is the fact that in many outbreaks staphylococci of several phage types are involved in addition to the epidemic strain.

DIAGNOSIS

DIFFERENTIATION between skin vesicles due to obstructed pores and early staphylococcal infection is usually easy by means of a Gram stain. Cultures take 24 hours and should be accompanied by antibiotic sensitivity determination by the disc technic.

Coagulase production should be determined on isolated organisms, and phage typing may be helpful in studying the epidemiology within the hospital. The epidemic strain is usually resistant to penicillin, streptomycin and tetracycline and sensitive to chloramphenicol, erythromycin, novobiocin and bacitracin.

TREATMENT

THE suspected lesion should be smeared for Gram stain and if still in doubt the patient should be isolated until the results of cultures are obtained. The infected infant should be isolated from healthy infants and treated with an effective antibiotic. *The nursery should be closed to new admissions.* Shaffer[6] advises that all babies in the nursery should receive a prophylactic course of erythromycin or other effective antibiotic to eliminate the carrier state and thus prevent subsequent infection in the infant or family contacts.

Staphylococcal pneumonia should be treated with two or more effective antibiotics and maintained for 3 weeks. Gamma globulin[13] may be added hopefully.[14] Empyema calls for surgical consultation. Localized pus requires warm dressings and incision and drainage. Infected dressings should be handled with instruments and burned.

CONTROL AND PREVENTION

IMMUNIZATION or *vaccination* against staphylococcal infections has so far not given much hope of being effective and would not be applicable to newborns.

Passive immunization for prophylaxis or therapy has not been promising. It has not received much attention in the United States. Recent therapeutic observations with gamma globulin suggest that hyperimmune serum deserves further study.

Staphylococci have become resistant to all antibiotics developed to date and it seems probable that new antibiotics if used unnecessarily like the old ones will also be only temporarily effective.

Fortunately, there is ample evidence [2,3,5,6] that the present wave of staphylococcal infections can be controlled by procedures available in every hospital. The most effective approach has been through drastic changes in the hospital environment. Many measures are of proved value while others are based on sound reasoning.

The following measures [12] will reduce, if not eliminate, infection in the nursery:

(1) Strict isolation of the nursery from other hospital personnel, including gloves, gowns and handwashing for visiting physicians.

(2) Reduce crowding of bassinets.

(3) Reduce airborne spread by oiling blankets, wet mopping of floors, damp dusting, burning of all dressings.

(4) Use of heat sterilizable bedding, mattress covers.

(5) Clean personnel and clothing. Nursery personnel should put on a clean gown when leaving nursery and discard on return.

(6) Good nursing technic.

(7) Improved handwashing between infants with hexachlorophene detergent.

(8) No common receptacles, tables or solutions for babies.

(9) Foot operated diaper disposal.

(10) Terminal sterilization of formulas.

(11) Careful instruction and education of personnel, and routine daily checking for compliance and for evidence of cutaneous infection among personnel.

(12) Search for and removal of carriers of the epidemic strain from the nursery and delivery room. New personnel should have 3 negative nasal cultures on alternate days. All nursery staff should have repeated cultures at regular intervals of 1 month. Two consecutive positive cultures for the epidemic strain should be an indication for removal from the nursery.

(13) Culture of the anterior nares of each infant at the time of discharge from the nursery has been recommended to detect the epidemic strain before it begins to cause widespread disease. This suggestion (and also No. 12) may be considered laborious and impractical. However, they test the efficacy of all the other measures in keeping the nursery free from the epidemic strain of staphylococcus. They give warning of its presence in time to take corrective measures before overt disease makes its appearance.

Many other tentative suggestions [12] have been made by the Committee on Fetus and Newborn of the American Academy of Pediatrics. Some of these are listed below:

(a) Continuous rooming in to avoid the nursery entirely.

(b) Small rotation nurseries instead of one large nursery so that the unit can be completely emptied and cleaned at frequent intervals.

(c) One hundred per cent outside air for premature incubators.

(d) Hexachlorophene-containing detergents for handwashing.

The following measures may be useful under certain circumstances or for therapy. They are not recommended as a routine because they give only partial protection at best and give a false sense of security. This may lead to neglect of more important control measures. In principle, they attempt to protect the infant in a contaminated environment rather than to eliminate the contamination:

(1) Antibacterial creams to suppress nasal carriers of staphylococci among personnel. Neomycin, bacitracin or chlorhexidine are preferable to the antibiotics which may be used systemically.

(2) Painting the umbilical stump with triple dye.

(3) Periodic bathing of newborn infants with a liquid detergent containing 3 per cent hexachlorophene. This delays pyodermia until after discharge from the nursery but does not eliminate it.[3]

(4) Prophylactic application of neomycin or bacitracin creams to the skin of infants.

Before complete control of staphylococcic infections is attained we need much more knowledge about epidemiology, immunity, mechanisms of drug resistance, role of various staphylococcic toxins and virulence factors,

and the role of the body's defensive mechanisms in producing the clinical disease patterns. More research funds should be directed to these studies.

SUMMARY

THE current widespread prevalence of serious staphylococcic infections in hospitals and nurseries and to a lesser extent in the community outside the hospital is not a new phenomenon. Such disease patterns, with minor variations, have occurred throughout medical history. The only new item is that such outbreaks have been rare for many years since the introduction of antibiotics and have now returned with the emergence of antibiotic resistant staphylococci.

Knowledge of the epidemiology, pathogenesis and immunity mechanisms are inadequate to explain all observations. However, years of experience have shown that infection is spread from one person to another and has indicated the hygienic measures necessary to prevent this spread.

Hospitals which have a high rate of infection or repeated epidemic and endemic outbreaks can most quickly remedy the situation by a thorough review and revision of the hospital environment. The effective measures for control are available and within the reach of every hospital.

Sheridan and Copewood Streets

A bibliographic list appears in Dr. Coriell's reprints.

Johnson Award to Dr. Oyer

The J. Fred Johnson Award for 1959 was given to Dr. Calvin E. Oyer of Kearny, N. J. Dr. Oyer had just concluded his residency at St. Michael's Hospital in Newark when he prepared a paper on the use of tolbutamide in diabetes. This was selected as the prize essay. The award will be made on Wednesday morning, April 29 during the meeting of the section on metabolism of The Medical Society of New Jersey.

The Johnson Award is administered by the New Jersey Diabetes Association for the best essay of the year. Candidates are restricted to New Jersey physicians who have been in practice less than five years or who are interns or residents in hospitals of this state. The award was made possible through the generosity of the late J. Fred Johnson who wished to stimulate the interest of young doctors in this disease.

Booklet on Congenital Cardiac Defects

A completely new edition of "*Diagnosis of Congenital Cardiac Defects in General Practice,*" by Dr. Regina Gluck, is available to physicians free of charge through the New Jersey Heart Association, 60 Park Place, Newark, N. J.

Primarily for general practitioners and pediatricians, the booklet clarifies the function of the family physician in diagnosing patients with congenital cardiac defects. It describes common defects. It presents the physiology and clinical findings and the indications for surgery in operable defects.

Thomas Pastras, M.D
Collingswood

Carcinoid Syndrome

The carcinoid syndrome is, in effect, something new in medicine—at least in terms of the possible relationship of serotonin to hypertension and valvulitis. Dr. Pastras here provides us with some food for thought.

In recent years, many medical and surgical specialties have indicated growing interest in carcinoid tumors. The symptoms and signs produced by carcinoid tumors are protean and involve many of the major organ systems. Many if not all of the various presenting features of the carcinoid syndrome may be attributed to one basic chemical, 5-hydroxytryptamine, or serotonin. The physiologic mechanisms of this chemical are currently being investigated. It is always gratifying to be able to correlate the patho-physiology of a disease process with its clinical expressions. This is well demonstrated by the carcinoid syndrome.

CARCINOID TUMORS

The original description of these tumors was written by Lubarsch in 1888. The now popular name *carcinoid* was introduced by Oberndorfer in 1907. Primary carcinoid tumors (argentaffinomas) may arise in any part of the gastro-intestinal tract from the gastric cardia to the anus, including the gall bladder. These tumors have been reported in the stomach, the duodenum, the jejunum, the ileum, Meckel's diverticulum, the appendix, the cecum, the colon and the rectum. They have been found in the gall bladder, and have been reported in teratomata of the ovary and testes when these tumors contain gastro-intestinal tissue. Ritchie[1] has calculated the frequency of these tumors as follows: the appendix (67 per cent), the jejuno-ileum (23 per cent), the colon (4 per cent), rectum (3 per cent), stomach (2 per cent), duodenum (1 per cent), gall bladder (0.2 per cent), and of unknown origin (1 per cent). Carcinoids of the appendix are more frequent in younger people, those primary elsewhere are more common in older people. Most authorities agree that the carcinoid tumor comes from the Kultschitzky cells in the crypts of Lieberkuhn. Kultschitzky cells have been given many names, including argentaffine cells, enterochromaffin cells, chromoargentaffine cells, chromaffin cells, chromaffril cells and basigranular cells. In man they are found in the epithelium of the gastrointestinal tract from the gastric cardia to the anus and in the epithelium of the large pancreatic ducts and the biliary system. These cells usually occur singly in between the epithelial cells, and are most common in the crypts of Lieberkuhn. They are columnar cells with their base attached to the basement membrane. The cytoplasm of the cell is clear and homogenous, but if properly fixed will demonstrate granules in the base of the cell. The nucleus is round and regular and is found in the center of the cell.

Morphologically the cells of carcinoid tumors resemble Kultschitzky cells. The histochemical reactions of the granules of carcinoid tumors are identical with those of Kultschitzky cells, and no carcinoid has been found primary at a site in which Kultschitzky cells are not found.[2] It has been demonstrated[3]

1. Ritchie, A. C.: American Journal of the Medical Sciences, 232:311 (March 1956).

that Kultschitzky cells secrete serotonin (5-hydroxytryptamine) into the blood. This amino-acid has been found in large quantities in carcinoid tumors, and in some cases is secreted into the blood stream.[4] Erspamer[3,5,6] reviews the origin and fate of 5-hydroxytryptamine. Page[7] has made a similar study. The most likely theory is that 5-hydroxytryptamine is formed from the amino-acid tryptophane by the Kultschitzky cells and is then secreted into the blood where most is taken up by the platelets. A large part is then "degraded" and excreted[7] in the urine as 5-hydroxyindole acetic acid.[3] It has not been established whether serotonin (5-hydroxytryptamine) serves any physiologic purpose. The normal value of 5-hydroxytryptamine is from 0.03 to 0.4 micrograms per cubic centimeter.* The normal urinary excretion in 24 hours of 5-hydroxyindole acetic acid is from 2 to 10 milligrams.

The essential clinical features of the *carcinoid syndrome* are referable to four systems: (1) the skin, (2) the gastro-intestinal tract, (3) the lungs, (4) the heart.

SKIN SYMPTOMS

THE most characteristic symptom is paroxysmal cutaneous flushing especially of the face, although the trunk and both upper and lower extremities may also be involved.[8] The cutaneous flushing is usually temporary. It may persist for as long as ten minutes. The cutaneous surface is of a bright red or bluish-red diffuse appearance with cyanotic patches throughout. When the flush subsides, the central portions fade first and it progresses peripherally resulting in serpiginous patterns. As the flushing becomes more chronic, telangiectases develop and a persistent cyanosis of the face results. The scleras are congested and reddened. The patient then has the plethoric appearance characteristic of polycythemia vera but without the hematologic changes and without clubbing of the fingers. The flush reaction may occur spontaneously or be precipitated by stimuli, such as the ingestion of spices, mechanical stimulation of the growth, emotional episodes, or ingestion of alcohol. The histology of the involved skin is nonspecific, showing dilatation and congestion of the veins and capillaries, thickening of the vessel walls, edema and a chronic inflammatory reaction.

GASTRO-INTESTINAL AND PULMONARY SYMPTOMS

DIARRHEA is often the first sign of the disease. As a rule this symptom continues throughout the course of the disease. The stool is watery and the number of movements per day may reach 20 to 30. Intermittent abdominal pain and borborygmi may be present.

The pulmonary symptoms are asthma-like with dyspnea and respiratory stridor.

CARDIAC SYMPTOMS

THE end results of the pathologic changes are that the tricuspid valves become stenotic or incompetent and the pulmonary valve stenotic and funnel-like. The pathologic changes in the heart are well described by McKusick,[9] and by Hedinger and Gloor.[10] The tricuspid and pulmonary valves become vascularized and sclerotic, thickened and distorted. The sclerotic tissue may extend to form well defined cushions overlying the intima of the pulmonary artery or the endocardium of the right atrium. It may extend into the thickened and fused cordae of the tricuspid valve. There may also be patches of endocardial fibrosis elsewhere in the right heart. The sclerotic tissue at times resembles cartilage. Microscopically, it is dense, acellular collagenous tissue with occasional collections of round

*Many writers give the normal value of serotonin as 0.13. However, the range from 0.03 to 0.4 is given by Udenfriend *et al.* 15.

2. Pearse, A. G. E.: *Histochemistry: Theoretical and Applied*. London 1954. J. & A. Churchill.

3. Erspamer, V.: Pharmacologic Review, 6:425 (April 1954).

4. Lembeck, F.: *Nature*, 172:910 (Sept. 1953).

6. Erspamer, V.: Triangle, Sandoz, Basle, Switzerland, 2:129 (1956).

7. Page, I. H.: Physiologic Review, 34:563 (May 1954).

8. Kierland, R. R., *et al.*: Archives of Dermatology, 77:86 (January 1958).

9. McKusick, V. A.: Bulletin of the Johns Hopkins Hospital, 98:13 (January 1956).

10. Hedinger, C. and Gloor, R.: Schweizer medizinische Wochenschrift, 84:942 (1954).

cells. The mitral and aortic valves are usually not affected.

In attempting to correlate the clinical syndrome with the biochemical changes, some investigators have shown that 5-hydroxytryptamine, when injected into animals, can cause changes similar to those seen in the syndrome, with the exception of the cardiac and valvular defects which are difficult to explain on this basis.[11]

METABOLIC AND NUTRITIONAL ASPECTS

It is worthwhile to mention that according to Spain,[12] some observers believe the cardiac changes to be the result of a nutritional deficiency, specifically of tryptophane. Large quantities of tryptophane have been found to be utilized by carcinoid tumors to form 5-hydroxytryptamine. In the South African Bantu the common occurrence of endocardial fibrosis is related to their low tryptophane diet. Along this same line, it is interesting to summarize a case reported by Bridges, Gibson, Loughridge and Montgomery[13] emphasizing the nutritional deficiency aspects of carcinoid syndrome. A 60 year old woman, while being treated for mitral stenosis for 3 years and well controlled, developed diarrhea. She had five or six watery movements daily preceded occasionally by mild abdominal cramps. One year later she noticed that the cutaneous surface of her hands, feet and legs became dry and developed a "withered" look. About the same time she became annoyed with facial flushing that often followed the ingestion of alcohol or hot drinks. Her face developed a reddish-blue discoloration in the distribution of the malar area, but of a brighter hue than that seen in mitral stenosis. Her skin was red-brown in color from the knees to the ankles. Barium enema x-rays demonstrated a deformity in the cecum suggestive of a neoplasm. Diarrhea persisted, her facial flushing became more frequent and her general condition gradually deteriorated until her death. At autopsy, a greyish tumor was found in the wall of the ileum. This tumor had infiltrated through the ileal wall and involved the adjacent lymph nodes. Extensive secondary deposits were present in the liver. This patient demonstrated pronounced skin changes, indistinguishable from pellagrous dermatitis.

The metabolism of the amino-acid tryptophane has been investigated in patients with carcinoid tumor[14] and metastasis.[15]

By using radioactive tryptophane and measuring the amount of radioactive 5-hydroxyindole acetic acid that appears in the urine, it was found, in one case, that the quantity of 5-hydroxyindole acetic acid in the urine varied according to the quantity of tryptophane fed. It was found that the intake of tryptophane necessary to maintain nitrogen balance was 500 milligrams a day, the normal requirement being 150 to 200 milligrams per day.[16] Therefore, it is thought that in some cases of extensive carcinoid, pellagra has developed because most of the tryptophane has been converted to 5-hydroxytryptamine.[14 17 18,19]

SUMMARY

The origin, nomenclature and histologic reactions of the carcinoid tumor are discussed. A relationship is becoming apparent between the major clinical expressions of the skin, gastro-intestinal tract, the lungs, and heart and the secretory product of the tumor, 5-hydroxytryptamine or serotonin. Examination of the urine for increased levels of 5-hydroxyindole acetic acid, the degradation product of 5-hydroxytryptamine, serves as laboratory confirmation of the clinical impression.

414 Haddon Avenue

11. Dewan, C. H. and Lindauer, R. G.: Bulletin of the Guthrie Clinic, 27:86 (1957).
12. Spain, D. M.: American Journal of Gastro-Enterology, 26:162 (February 1956).
13. Bridges, J. M., *et al.*: British Journal of Surgery, 45:117 (August 1957).
14. Sjoerdsma, A., *et al.*: American Journal of Medicine, 20:520 (June 1956).
15. Udenfriend, S., *et al.*: Science, 123:669 (1956).
16. Rose, W. C., *et al.*: Journal of Biologic Chemistry, 211:815 (August 1954).
17. Curiens, J. H., *et al.*: American Heart Journal, 30:491 (April 1945).
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Diagnostic Value of Radiologic Studies in Liver Disease*

Clinical studies and liver function tests constitute the traditional tools for the study of liver disease. As is shown here, however, modern radiography has added a new technic and a new dimension to these studies.

A variety of radiologic procedures are currently available which directly or indirectly help the clinician evaluate the functional status of the liver. These include abdominal scout films; cholecystographic and cholangiographic visualization of the extra and intrahepatic biliary network; barium studies of the esophagus; and opacification of the venous system of the liver and its tributaries. It is the purpose of this paper to review the indications and usefulness of these technics in patients with suspected or proved primary liver disease.

Abdominal Scout Films

Increased densities within the substance of the liver on abdominal scout films permits recognition of hemosiderosis, hepatic calculi, calcified cysts, hemangiomas, granulomata, and scleroderma. Gross hepatomegaly may be demonstrated in abdominal scout films and is suggested by an elevated right leaf of the diaphragm. Diaphragmatic elevation is characteristic of liver abscess and is helpful in confirming this diagnosis. Less frequently, metastatic malignancy and degenerative or inflammatory lesions of the liver may be accompanied by upward enlargement. Roentgen estimation and measurement of liver size are not reliable. Their usefulness is confined to serial studies employing standard positions and technics to demonstrate the effect of therapy on liver size as well as changes in size during the natural course of known disease (Fig. 1). Gastric and colonic air contrast may help localize liver borders in ascites and obesity.[1]

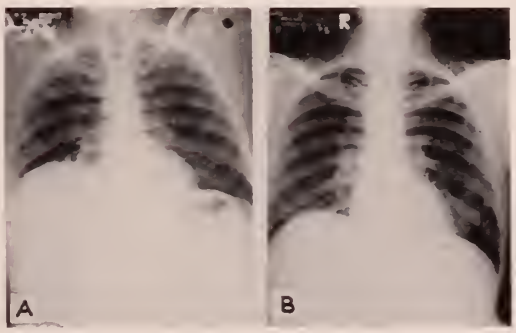


Fig. 1A. Elevation of right diaphragm in decompensated nutritional cirrhosis.
Fig. 1B. Comparative study after 4 months of therapy with reduction in liver size and disappearance of evidence of liver failure.

*Read at the Section on Radiology, Annual Meeting of The Medical Society of New Jersey, May 20, 1958. This work is from the Department of Radiology and the Hepatic Metabolic Research Unit, Jersey City Medical Center and Seton Hall College of Medicine.

THE diagnostic value of cholecystography in extrahepatic biliary disease is well established. Nonvisualization of the gall bladder occurs in most subjects where jaundice is due to biliary obstruction of either intrahepatic or extrahepatic origin. In jaundice due to liver cell dysfunction there is usually nonvisualization of the gall bladder. However, the nature of the underlying liver disease is more important than the degree of icterus in determining response to cholecystography. Normal visualization is to be expected in metastatic liver disease, hepatic congestion, or cirrhosis without jaundice, and in viral hepatitis when the serum bilirubin is less than 8 milligrams per cent.[2] In constitutional hyperbilirubinemia[3] the gall bladder normally visualizes, whereas in the closely related Dubin-Johnson syndrome[4] it does not, thus aiding in the differential diagnosis. The ability of the gall bladder to visualize in hepatic cirrhosis is directly related to severity of the disease.[5] This is of considerable importance in deciding the significance of symptoms which are compatible with either cholelithiasis or liver dysfunction. In a study of 100 patients with biopsy-proved cirrhosis, the capacity of the gall bladder to visualize (using a double dose of the contrast media after failure to obtain results with a single dose) depended upon the clinical, biochemical and morphologic severity of the disease. Normal responses occurred in 23 patients with mild to moderate Laennec's cirrhosis without clinical evidence of hepatic failure. There was nonvisualization in 77 patients with cirrhosis accompanied by icterus, ascites, hepatic fetor, high levels of bromsulfalein retention, and positive flocculation tests. Improvement in hepatic reserve was often followed by restoration of the capacity to visualize the gall bladder (Table 1). In patients with compensated cir-

1. Zelman, S.: Liver and Spleen Visualization by Roentgen Contrast Media, Ann. Int. Med., 34:466 (1951).

2. Readinger, H. M., *et al.*: Oral Cholecystography in Viral Hepatitis, Am. J. Med., 8:611 (1950).

3. Comfort, M. W. and Hoyne, R. M.: Constitutional Hepatic Dysfunction, *Gastroenterology*, 3:155 (1944).

4. Dubin, I. N. and Johnson, F. B.: Jaundice with Unidentified Pigment in Liver Cells, *Medicine*, 33:155 (1954).

5. Cunniff, C. L., Dolan, M. A. and Leevy, C. M.: Cholecystography in Cirrhosis Without Jaundice, *Gastroenterology*, 25:557 (1953).

TABLE 1.

IMPROVEMENT IN GALL BLADDER VISUALIZATION USING 6 TABLETS OF IODOPANOIC ACID* FOLLOWING THERAPY

Clinical:	Initial Study	After 6 Weeks Therapy
Icterus	0	0
Spider angiomata	1 +	1 +
Hepatomegaly	2 cm.	0
Ankle edema	1 +	0
Biochemical:		
Serum bilirubin	1.2	0.8
Alkaline phosphatase	6.6	6.5
B.S.P. retention	36%	20.5%
Serum cholesterol	194 mg.%	260 mg.%
Cholesterol esters	109 mg.%	85 mg.%
Serum albumin	2.9 gm.%	3.0 gm.%
Serum globulin	3.9 gm.%	2.4 gm.%
Cephalin flocculation	4 +	2 +
Histologic:		
Fibrosis	2 +	2 +
Fat	2 +	0
Inflammation	2 +	1 +
Necrosis	1 +	0
Gall bladder visualization	Poor	Good

rhosis, cholecystitis or cholelithiasis should be suspected when a gall bladder fails to visualize after a double dose of iodopanoic acid.†

The following case history is illustrative:

CASE ONE

A 62-year old laborer was hospitalized because of recurrent upper abdominal distention and an "uncomfortable feeling" after meals. There was a past history of poor dietary habits and alcoholism. Examination revealed an enlarged firm liver extending 8 centimeters below the right costal margin in the midclavicular line. There was no other stigmata of liver disease. Biochemical liver function tests were normal. Cholecystography using 6 and 12 tablets of iodopanoic acid† failed to demonstrate a gall bladder shadow. Since there was no clinical or laboratory evidence of liver failure to account for the nonvisualization, a diagnosis of cholecystitis with lithiasis and compensated nutritional cirrhosis was made. Surgical biopsy of the liver was done along with a cholecystectomy. A single stone was present in the cystic duct of an enlarged, inflamed gall bladder; a concomitant liver biopsy showed moderate cirrhosis. Postoperatively, the patient has been asymptomatic.

This case history is typical of 19 patients observed over an 8-year period with both liver and gall bladder disease. The high incidence of cholelithiasis in patients over 50 years of age and the apparent increased incidence of gallstones in patients with chronic liver disease[5] make it desirable to suspect concurrent gallstones in all older patients with hepatic abnormalities. Occasionally, an abdominal scout film will reveal calcified stones and there is no problem in diagnosis. In most instances, cholecystography is necessary to rule out the presence of gallstones which might insiduously contribute to progression of the hepatic disease by causing intermittent biliary obstruction or nutritional deficiencies due to food intolerance.

Intravenous, transcutaneous, operative, and "T"-tube cholangiography have each been of value in selected patients with primary liver disease. Intravenous cholangiography[7] has been particularly helpful in cholecystectomized patients exhibiting hepatomegaly. In four patients, this examination revealed a dilated common duct and the mechanism responsible for the presenting signs and symptoms. The triad of a dilated common duct, an elevated serum alkaline phosphatase, and portal inflammation or fibrosis on liver biopsy is diagnostic of extrahepatic biliary obstruction.

Percutaneous hepatic cholangiography[8] which is currently used in the department of surgery as a research tool, may occasionally be valuable in differentiating intrahepatic and extrahepatic cholestasis. However, in our experience operative or "T"-tube cholangiography[9] is safer and more reliable. This latter technic is indispensable in differentiating primary cholangiolar disease and neonatal hepatitis from extrahepatic biliary obstruction. Surgical exploration with cholangiography and biopsy is indicated with persistent jaundice of this origin in order to be certain of the diagnosis.[10] The following case history is illustrative:

CASE TWO

A 46-year old housewife was hospitalized because of jaundice associated with pruritis and epigastric distress. Three months earlier she had received transfusions during a hysterectomy. Examination revealed jaundice and hepatosplenomegaly. Biochemical tests yielded evidence of biliary obstruction. Liver biopsy showed bile stasis as the only abnormality. On exploratory operation, no extrahepatic obstruction was found and a cholangiogram was entirely normal. Postoperatively, she improved temporarily on adrenal steroids but subsequently had a relapse with progressive development of portal fibrosis, portal hypertension, and bleeding varices. Four years after onset of the illness she had well established biliary cirrhosis and subsequently died.

Throughout this patient's illness the mechanism of her jaundice was questioned. The operative cholangiogram provided the major basis for supporting a diagnosis of primary cholangiolar disease confirmed subsequently at postmortem examination. Cholangiograms obtained in patients with identical clinical fea-

†We use the Winthrop brand of iodopanoic acid, tradenamed Telepaque®.

6. Lieber, M. M.: The Incidence of Gallstones and Their Correlation with Other Diseases, Ann. Surg., 135:394 (1952).

7. Sutton, D.: Radiology of the Biliary and Portal Systems, British Med. Bull., 13:99 (1957).

8. Novrick, A. W.: Percutaneous Transhepatic Cholangiogram in Obstructive Jaundice, British J. Surg., 41:27 (1953).

9. Norman, O.: Studies on Hepatic Ducts in Cholangiography, Acta Radiol., sup. 84 (1951).

10. Leevy, Carroll M.: Intrahepatic Cholestasis, Am. J. Surg., In Press.

tures may show a high hepatic duct obstruction. See Figure 2.

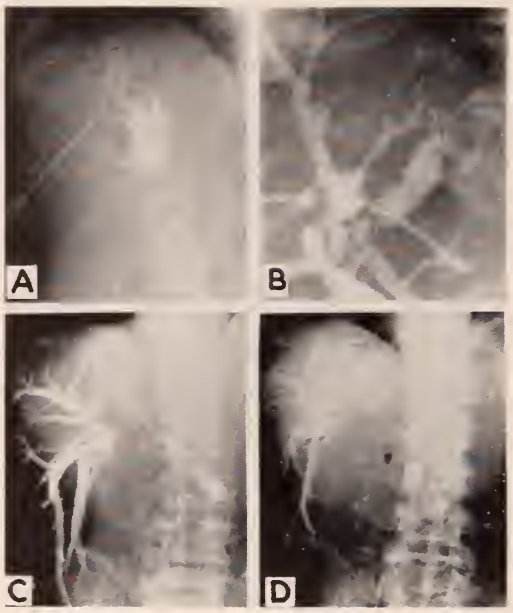


Fig. 2A. Percutaneous cholangiogram showing high hepatic duct obstruction incident to sclerosing cholangitis.

Fig. 2B. Same, postoperatively: T-tube cholangiogram reproducing and confirming findings of percutaneous study.

Fig. 2C. Percutaneous cholangiogram demonstrating high hepatic duct block due to metastatic carcinoma.

Fig. 2D. Trapping film 15 minutes after "C".

BARIUM STUDIES

EVERY patient with hepatic cirrhosis should be suspected of having esophageal varices [11] and, as an integral part of his laboratory studies, should have an esophagram to determine their extent. Esophagoscopy and splenoportography are better methods for identifying esophageal varices but these approaches may not be available. The usefulness of esophagrams in recognizing varices has been questioned but the ratio of positive results is closely related and proportional both to the care and technic used. Proper spot filming, using a thick barium cream swallowed during the Valsalva maneuver and then obtaining films with the patient horizontal in the right anterior oblique position, has increased the number of positive results in our experience. Deviation of the normal mucosal folds showing grape-like clusters or scalloping permits a diagnosis of varices.

The increased incidence of peptic ulceration [12] and gastritis in cirrhosis makes it desirable to obtain a gastro-intestinal series in these patients, especially where adrenal steroids are to be given. In seven of our patients with massive gastro-intestinal hemorrhage there has been radiographic demonstration of both esophageal varices and a duodenal ulcer. Small bowel x-rays in severe cirrhosis may often reveal a deficiency pattern. The concomitant poor absorption of food contributes further to the signs and symptoms of malnutrition. With recovery from hepatic disease, serial studies frequently show improvement in the pattern.

HEPATIC VENOGRAPHY

ROENTGENOGRAPHIC study of the venous inflow and outflow tracts of the liver by percutaneous splenoportography,[13] transhepatic venography,[14] operative portal venography, and hepatophlebography [15] have been widely used to investigate patients with liver disease who exhibit clinical manifestations of portal hypertension. Splenoportography is a relatively simple technic. A 3 inch, 18 gauge needle is introduced *via* the 8th or 9th intercostal space. A saline manometer is attached for measurement of splenic pulp pressure. Then, after fluoroscopically ascertaining that the needle tip is in a venous pool, 40 cubic centimeters of 70 per cent sodium acetrizoate* are quickly injected into the splenic pulp while serial x-rays are rapidly obtained. This procedure should be undertaken cautiously and is contraindicated in the presence of a bleeding ten-

*We used the Mallinckrodt brand of sodium acetrizoate, tradenamed as Urokon®.

11. Leevy, Carroll M.: Practical Diagnosis and Treatment of Liver Disease, Paul B. Hoeber, Inc., 1957.

12. Lipp, W. F. and Lipsitz, M. H.: Peptic Ulcer and Portal Cirrhosis with Massive Hemorrhage, *Gastroenterology*, 22:181 (1952).

13. Turner, M. D., Sherlock, S. and Steiner, R. E.: Splenic Venography and Intrasplenic Pressure Measurement in the Portal Venous System. Am. J. Med., 23:846 (1957).

14. Bierman, H. R., *et al.*: Transhepatic Venous Catheterization and Venography, J.A.M.A., 158:1331 (1955).

15. Leevy, Carroll M. and Gliedman, M.: Hepatic Vein Catheterization. New England J. Med., 258:696, 1958. II. Ibid 258:738 (1958).

dency, sensitivity to the contrast medium, jaundice, and ascites. Complications vary with the experience of the operator and selection of patients. Hemorrhage represents the chief cause of morbidity and mortality. In a series of 53 splenoportograms at the Jersey City Medical Center, one patient had a massive intraperitoneal hemorrhage and two developed a slight intraperitoneal hemorrhage which stopped spontaneously.

A normal splenoportogram demonstrates contrast medium in the spleen, splenic vein, extrahepatic portal vein and in the intrahepatic portal veins which are normally long and straight, arborize freely, and approach close to the liver periphery (Fig. 3A). Splenoportography has been used to investigate primary or metastatic carcinoma of the liver, and evaluate ascites or splenomegaly of undetermined origin in hepatic disease. It is particularly useful in studies of patients with portal hypertension as it helps to decide the cause of an elevated portal pressure, to identify esophageal and other collaterals, and to determine the patency of a porta caval shunt postoperatively. The value of this procedure in differentiating extrahepatic and intrahepatic causes of portal hypertension has been well documented.[11] Less well known is its use in combination with wedged hepatic vein pressure to evaluate the need for shunt surgery, and its place in establishing the basis for mental disturbances in liver disease. The following case histories are illustrative:

CASE THREE

A 68-year old bartender was hospitalized because of ascites and ankle edema of 3 weeks' duration. It had been his custom to drink, every day, 6 to 8 glasses of wine. He subsisted on an inadequate diet. Examination demonstrated marked ascites, ankle edema, and a ballotable liver. Biochemical study showed bromsulfalein retention and hypoalbuminemia. Liver biopsy revealed moderate cirrhosis. A wedged hepatic vein pressure after paracentesis was 22 millimeters of mercury. Repeat pressure studies after 3 months of therapy showed no change. A splenic pulp pressure was 14 millimeters of mercury, and a splenoportogram showed no esophageal varices but demonstrated collaterals which entered the inferior mesenteric system. On basis of the pressure studies and splenoportography, it was evident that this patient had spontaneously lowered his intrasplenic pressure and did not require surgical portal decompression.

Simultaneous studies of wedged and intrasplenic pressures show close agreement in most instances. The intrasplenic pressure was lower than the wedged pressure in 3 patients in whom numerous extrahepatic collaterals could be demonstrated on splenoportography (Fig. 3B), and considerably higher than the wedged pressure in two subjects with complicating portal vein thrombosis,[16] one of whom spontaneously developed a splenorenal shunt (Fig. 3C).

CASE FOUR

A 52-year old woman was hospitalized on 3 occasions because of mental clouding and depression. Examination revealed a flapping tremor, lethargy, hypersomnia, incoordination, and constructional apraxia. Biochemical tests showed bromsulfalein retention, a low serum albumin, an elevated blood ammonium, and a positive cephalin flocculation test. Moderate inactive cirrhosis was present on liver biopsy and a splenoportogram showed marked collaterals entering the superior mesenteric system (Fig. 3D). On a regimen of restricted protein and antibiotics, her sensorial changes disappeared.



Fig. 3A. Normal splenoportogram.

Fig. 3B. Splenoportogram showing collateral filling of the inferior mesenteric system.

Fig. 3C. Splenoportogram showing portal vein obstruction, a dilated coronary vein leading to esophageal varices, a large splenic vein with reflux into the inferior mesenteric and formation of a spontaneous splenorenal shunt.

Fig. 3D. Splenoportogram showing marked collateralization via the superior mesenteric, ileocolic, right colic and pelvic veins, eventually emptying into the lumbar veins.

This case history is representative of a large segment of patients with liver disease who exhibit neurologic and psychiatric disturbances. Mental alterations are frequently due to ammonia intoxication. Blood ammonia may be elevated in hepatic disease due to an inability of poorly functioning liver cells to conjugate ammonia to urea, or because of spontaneous or surgically produced shunts which allow absorbed intestinal ammonia to bypass the liver. The presence of the latter mechanism can be best determined by splenoportography.

HEPATIC PHLEBOGRAPHY

THE hepatic venous network may be visualized by introduction of contrast media through a catheter in the hepatic vein. Introduction of 50 cubic centimeters of an appropriate contrast medium with x-rays obtained at 10 second intervals usually provides ample visualization. A double lumen catheter with an inflatable balloon connected to one lumen prevents reflux of the contrast medium and facilitates injection. This permits visualization of the outflow tract of the liver (Fig. 4) and in combination with splenoportography provides a complete account of the venous network of the liver. It is of value in locating space occupying lesions and determining the patency of the hepatic veins.[15]

Of equal value is the use of hepatic phlebography during hepatic vein catheterization for pressure measurements, estimation of hepatic blood flow, and metabolic studies. Introduction of contrast media has been invaluable in identifying the location of the catheter tip which may occasionally enter a renal vein, diaphragmatic vein, or other non-hepatic vessel.

SUMMARY AND CONCLUSIONS

1. Radiologic technics now constitute an essential part of the evaluation of patients with suspected or proved hepatic disease. They are of greatest value when combined with clinical, biochemical, physiologic and histologic studies.



Fig. 4. Hepatophlebogram showing catheter in place and contrast medium in a segment of the right hepatic lobe.

2. Modification of standard technics for abdominal scout films and barium study of the esophagus increases the diagnostic value of these procedures in serial evaluation of the size of the liver and in detecting esophageal varices in hepatic cirrhosis.

3. Cholecystography is of value in estimating hepatic functional reserve and permits discovery of unsuspected gallstones in established liver disease. Cholangiography is indispensable to rule out extrahepatic lesions in patients with persistent jaundice attributed to intrahepatic mechanisms leading to biliary obstruction.

4. Contrast visualization of the venous system of the liver by percutaneous splenoportography and hepatophlebography is invaluable in study of the patient with portal hypertension; facilitates recognition of vascular anomalies and space occupying lesions; and serves as a guide in hepatic vascular surgery.

The authors gratefully acknowledge the contributions of Drs. Rahim Farid and Julius Baber of the Department of Surgery for reported studies involving percutaneous cholangiography and splenoportography.

Jersey City Medical Center

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State Activities • • •

Special Committee on Retirement Plan for Physicians

JEROME G. KAUFMAN, M.D., Chairman

In compliance with the directive of the 1958 House of Delegates, early in the administrative year, the President appointed a three-man probing committee to study and prepare recommendations concerning the purpose and intent of the Mercer County Resolution dealing with a retirement plan for physicians in affiliation with the Medical-Surgical Plan of New Jersey.

That committee held two meetings in the course of its investigations and obtained permission of the Board of Trustees to avail itself of the services and advice of the Society's legal counsel.

The President then brought the committee to its full complement. The full committee met on March 8, to receive the report of the work done by the probing committee.

Dr. Moriconi explained the nature and intent of the Mercer County Resolution. Extended discussion from the floor followed. All of the speakers expressed disapproval of the proposal to create the retirement plan by means of contributions from Medical-Surgical Plan—regarding the proposal as of doubtful legality and morality.

Legal counsel, Mr. Backes, then presented his opinions concerning the acceptability and feasibility of the proposal. Mr. Backes said, in effect that the proposal contained in the Mercer County Resolution—that the Medical-Surgical Plan participate in the foundation of the retirement fund—called upon the corporation to act beyond the purposes for which under the law it was set up. He also made it clear that in his opinion the proposal very definitely raised a serious moral issue.

Dr. Moriconi then moved that the retirement plan as embodied in the Mercer County Resolution be disapproved. Dr. Lloyd seconded. The motion was unanimously adopted.

Then, upon suggestion of President Gardner, the committee unanimously adopted a motion to empower a subcommittee of the full committee, with Dr. Kaufman as chairman, to study the possibility of the establishment of another type of retirement plan for members of The Medical Society of New Jersey, and to prepare recommendations with reference thereto.

Nurses and Intravenous Therapy

The Board of Trustees of The Medical Society of New Jersey, on January 18, 1959, directed that the following statement by the State Board of Medical Examiners be published for the information of our members.

Concerning the right of nurses to administer intravenous medications or other forms of intravenous therapy, including infusions and transfusions, there are two statutory references to be quoted as the point of departure:

1. The Medical Practice Act, 45:9-21, Certain persons and practices excepted from operation of Chapter.

The prohibitory provisions of this chapter shall not apply to the following: k . . . a . . . professional nurse . . . while operating in each particular case under the specific direction of a regularly licensed physician or surgeon. This exception shall not apply to such assistants of persons who are licensed as osteopaths, chiropractors, optometrists or other practitioners holding limited licenses.

2. The Nursing Practice Act, 45:11-23 b. . . "Professional Nursing" is the performance for compensation of any professional service requiring the application of principles of nursing based on biologic, physical and social sciences, including responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts and the carrying-out of treatments and medications

prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health of a patient and others.

When the present Medical Practice Act was written in 1939 the terms "professional nurse" and "trained nurse" were synonymous, indicating a person who, after satisfactorily completing the prescribed course of study in a legally constituted school of nursing, had had a certificate as a Registered Nurse conferred upon her.

Appropriate consideration having been given to the two foregoing definitions it is the opinion of the State Board of Medical Examiners of New Jersey that persons who have been duly licensed as "professional nurses"—*i.e.*, those who hold certificates as Registered Nurses—may properly administer intravenous medications and/or other forms of intravenous therapy (including transfusions as well as infusions) when such are given under the specific direction of a regularly licensed physician or surgeon in each particular case. This authorization includes such procedures either in the hospital or elsewhere under the conditions stipulated. It is not necessary for the physician actually to be present in person when the intravenous medication or therapy is being administered.

It is expected, however, that the physician will have assured himself that the nurse to whom he delegates such important and potentially dangerous procedures has had adequate training in the conduct of these forms of therapy.

It is expected also that the Directors of Nursing of all hospitals will have similarly assured themselves of the competence of nurses assigned to this duty.

In the circumstances, the safety and welfare of the patient are the paramount considerations. Furthermore, prudence dictates that the possibility of malpractice suits against the doctor, the hospital or the nurse herself be constantly borne in mind to the end that only nurses with proper training and technic be assigned to this duty.

It is beyond the purview of the Board of Medical Examiners to determine how the necessary instruction for the training of nurses in the administration of intravenous therapy shall be given. It is suggested, however, that the required instruction not be made part of the curriculum of all student nurses; but, that following graduation, nurses with the requisite interest, aptitude and skill be selected and specially trained.

Pediatric Oncology Course

A 3-day course in pediatric oncology is announced for the period beginning April 29. Registration fee is $35. The course is held at the Memorial Center, 444 East 68 Street, New York, and details may be obtained from the Chief of Pediatrics at that address. The course covers the diagnosis and management of tumors in children, including leukemia and reticulo-endothelioses.

New Pediatric Director at St. Michael's Hospital

George A. Maggio, M.D., has been appointed Director of Pediatrics at St. Michael's Hospital, Newark, succeeding Dr. Harrold A. Murray who founded the department. Dr. Maggio is a native Newarker who received his medical degree in 1931 from George Washington University. He is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. He is a Past-President of the Newark Lions Club and a Past Deputy District Governor of Lions International in New Jersey.

Announcements • • •

Psychiatric Research Meeting

A galaxy of stars is announced for the speakers' platform at the annual meeting of the Eastern Psychiatric Research Association. The meeting will open promptly at 8 p.m. Friday evening, April 24 at the Alumni Hall in the basement of the N.Y.U. medical school on First Avenue at 30th Street, New York City. Ample parking space is provided on the grounds if you enter through the First Avenue gateway. Dr. Ugo Carletti of Italy, the distinguished pioneer in electroshock will speak on newer trends in e.c.t. The Chief of Research at the VA Hospital in Pittsburgh, Dr. Amadeo Marazzi, will discuss "abnormal cerebral transmission." And then there will be general floor discussion—with no set speech—on drug therapy in psychiatry. No registration fee—just be there at 8 p.m. April 24.

American Heart Association

The Annual Meeting and Scientific Sessions of the American Heart Association will be held October 23 to 27 in Philadelphia. The Scientific Sessions are scheduled for October 23 to 25. The Annual Meeting of the National Assembly will be at the Hotel Bellevue Stratford, October 26 and 27.

A June 12 deadline is set for submission of abstracts of papers to be presented at the meeting. Papers intended for presentation must be based on original investigation in, or related to, the cardiovascular field. Forms for submitting abstracts and space applications for scientific exhibits may be obtained from Dr. F. J. Lewy at the American Heart Association. Applications for space for industrial exhibits may be requested from Steven K. Herlitz, Inc., 280 Madison Ave., New York 16, N. Y.

Inquiries concerning hotel reservations and Assembly meetings may be addressed to William F. McGlone, American Heart Association, 44 East 23rd Street, New York 10, N. Y.

Mental Retardation Conference

Expect to be in Maine this summer? If so, you will be interested in an intensive conference on Mental Retardation to be held in Portland July 27 through 31. This is the first international seminar on the subject to be held in the U.S.A.

For further details, write to Conference on Mental Retardation at the Eastland Hotel, Portland, Maine.

Physicians Needed for Federal Service

The United States Government needs doctors for services both here and in foreign posts at salaries ranging from $8,000 to $13,000 a year. Physicians are needed for the Public Health Service, the Veterans Administration, the Indian Service, the National Institutes of Health, St. Elizabeth's Hospital in Washington, the Children's Bureau, the Food and Drug Administration, and for Army, Navy and Air Force installations.

There are many fringe benefits available to physicians who enjoy working in a medically centered setting. Further details may be obtained from the U. S. Civil Service Commission, 641 Washington St., New York, N. Y.

American Academy Monograph Prizes

A thousand-dollar prize awaits the writer of a winning monograph on some phase of the biological sciences. This is administered by the American Academy of Arts and Sciences. A monograph is defined as a "scholarly contribution too short (or too specialized) for a book and too long for an article." Deadline is October 1, 1959. For details, write to Monograph Committee, American Academy of Arts and Sciences, 280 Newton Street, Brookline 46, Massachusetts.

Obituaries • • •

DR. WILLIAM J. CROOKS

A heart attack took the life of 57-year old Dr. William J. Crooks, 3rd, of Clinton on February 14, 1959. Born in Newark, Dr. Crooks was graduated in 1932 from the medical school of Tufts University. After interning at the Martland Medical Center in his native city, Dr. Crooks opened an office there and joined the Essex County Medical Society. He retained his membership in that component even after moving to Hunterdon County, which he did in 1937. From 1937 to 1943, Dr. Crooks operated the only general hospital in Hunterdon County. After leaving that hospital, Dr. Crooks did general practice in the Clinton-Glen Gardner area. He was on the surgical staff at the Clara Maass Hospital in Belleville at the time of his death.

DR. GEORGINA U. CRAWFORD

One of Essex County's most beloved medical figures, Dr. Georgina U. Crawford, died on February 2, 1959 at the age of 76. A 1905 graduate of the University of Toronto medical school, Dr. Crawford interned in New York City, and in 1908 came to the then semi-pastoral village of East Orange. Here she married, raised two sons, and engaged in an extensive private medical practice. She was also a consulting physician for the New Jersey Bell Telephone Company, and for the Girls Vocational School in Newark. She served the outpatient department of the Orange Memorial Hospital for many years.

DR. THEODORE R. FAILMEZGER

Dr. Theodore R. Failmezger of Clearwater, Florida, a former well-known Morris County internist, was shot and killed by a paranoid patient on February 7, 1959. Dr. Failmezger was born in 1904, and in 1934 was graduated from the Jefferson Medical College. He moved to Madison, N. J. and served the people of that county from 1936 until the summer of 1958 when he moved to Florida. Dr. Failmezger had been president of the Morris County Medical Society. He was a diplomate in internal medicine, and on the staff of both Morristown Hospitals. He was active also in the affairs of the American Geriatric Association and the New Jersey Diabetes Society. He was a model railway enthusiast, whose train collections were known to railroad hobbyists throughout the country.

DR. ALBERT E. MAGSON

One of Hightstown's best known general practitioners died on February 1, 1959 after a long illness. He was Dr. Albert E. Magson, a 1938 graduate of the Philadelphia Hahnemann Medical College. Born in Philadelphia in 1912, Dr. Magson established an office for general practice in Hightstown after his internship in 1939. He was a member of the well known United States Power Squadron and active in the affairs of the Hightstown Grange. Dr. Magson belonged to the Mercer County Medical Society.

County Societies Reports • • •

Atlantic

The monthly meeting of the *Medical Society of Atlantic County* was held Friday, January 9, at the Children's Seashore House, with the president, S. Eugene Dalton, in the chair.

Dr. Samuel Southard of the Public Health Committee, summarized his investigation of the Venereal Disease Survey conducted by the New Jersey State Department of Health, which occurred in Atlantic City in September and October, 1958.

Dr. Gleason, reporting for the Insurance Committee, asked authority to canvass the membership regarding subscription as a group to the Medical-Surgical Plan of New Jersey; secondarily, if the minimum percentage of 50 per cent of our members favor such a group subscription, then such approval would automatically constitute endorsement by the Society of this project; and Dr. Gleason then asked that he be further empowered to carry out such negotiations with the Medical-Surgical Plan of New Jersey as are necessary to render such groups of subscriptions effective as of July 1, 1959. This motion was passed unanimously.

The speaker for the evening was Truman G. Schnabel, Jr., M.D., Associate Professor of Medicine at the University of Pennsylvania. His subject was "Recent Advances in Cardiology."

Discussors were: Dr. James Gleason, Dr. Milton Cutler, Dr. Samuel Kaman, Dr. Peter Marvel and Dr. Irving Shavelson. All speakers thanked Dr. Schnabel for a fine lecture.

There being no further business, the meeting was adjourned.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society*, held March 10 at Bergen Pines Hospital, Paramus, was called to order by George Heller, M.D., President, at 9:07 p.m., a quorum being present.

The Secretary read the following names, which had been approved by the Executive Committee for election to membership:

To Regular from Associate—Regina Kesler, Thomas H. Smith; To Regular by Transfer—Nolton H. Bigelow (from County of Albany, N. Y.), Abraham Goldfarb (from Passaic County), Martin Silbersweig (from County of New York); To Regular—Edna M. Habeeb; To Associate—Ismail F. D'Javid, John R. Doyle; To Courtesy from Regular—Charles Abbott, Sidney S. Boyers; Leave of Absence—Armin W. Doctor—due to illness.

The applicants were all elected by unanimous vote.

Dr. Campbell reminded the members about the public forum on diabetes to be held at the Bergen Mall Auditorium co-sponsored by the *Bergen Evening Record*. The *Record* had already received 750 requests for the St. Louis Drei-Paks from the public, all of which came from the paper's daily advertising. He urged that members recommend attendance by their diabetic patients and their families.

Dr. R. William Jewell, Chairman of the Historical Committee, read a citation conferring the title of Honorary Member on William Carlos Williams, M.D.

After being regularly moved and seconded, that the title of Honoray Member be conferred on Dr. Williams, it was unanimously passed.

In reply to the citation, Dr. Williams stated that "You are all my pals and I am proud to have been a physician. This is my home and whatever distinction I have achieved, stems from the conviction that in the United States, we speak our own language, not just English. This is my inspiration. The American idiom is my forte and I am proud to be known as a poet and proud to have been a Doctor."

The next item on the agenda was the scientific program: a discussion of the mission and operations of the county Medical Examiner's office. The speaker was Dr. Lawrence Denson, Assistant County Medical Examiner. This was followed by a further discussion of the Medical Examiner system vs. the Coroner system, led by Dr. David Spain, Assistant Professor of Pathology at Columbia University's College of Physicians and Surgeons.

At the resumption of the business meeting, the Society voted to endorse the Interprofessional Code for Physicians and Attorneys as published in the JOURNAL of The Medical Society of New Jersey (February 1959 issue).

The nominating committee offered the names of Drs. D. B. Hull, G. O. Rowohlt, Walter Wahrenberger, Charles Campbell, J. P. O'Connor, A. A. Alessi and J. E. McWhorter for the positions of president, two vice-presidents, secretary, treasurer, assistant treasurer and judicial committeeman, respectively.

The Society adopted a resolution offered by Dr. Palazzo, "favoring the AMA suggestions to formulate a Blue Shield plan for medical care of senior citizens" whereby premiums and fees would be proportionately scaled downward for citizens of limited means. Dr. Palazzo also urged that letters be written to Congressman Widnall and Congressman Osmers urging them to vote for Keogh-Jenkins bill.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The third meeting of the *Camden County Medical Society* convened March 3 at Kenny's Restaurant in Camden. A dinner preceded the meeting at which 57 members and four guests were present. Dr. Elic A. Denbo presided.

The following new members were introduced after signing the Register and taking the oath: Drs. James E. Brennan, S. Lee Kuensell, J. W. Fessman, J. A. Sosa, Arthur A. Hartley, Raymond A. Davis, David H. Black, Charles J. Volpe, Nemorio Galindo, Paul D. Rahter, Robert J. Trollinger and Robert S. Gamon, Jr.

Dr. Matthew A. Olivio, Chairman of the Program Committee, introduced the speaker of the evening, Dr. Kenneth W. Warren, Attending Surgeon, Lahey Clinic. Dr. Warren presented a paper on "Some Common and Uncommon Problems of the Biliary Tract."

Dr. Robert N. Bowen read a memoir on the death of Dr. Clinton P. Sheaffer. The memoir had been prepared by Dr. Kenneth L. Athey.

Dr. I. E. Ornaf, Chairman of the Nominating Committee, proposed the name of Dr. Matthew A. Olivio as Delegate and Dr. Edward Mazur as Alternate to the State Society Convention. These were duly elected.

E. H. KAIN, M.D.

Reporter

Cumberland

The February meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake, on February 10, with the president, M. David Baxter, M.D., of Vineland, in the chair. The incoming president, Dr. Berkowitz, announced that he had planned to appoint a committee on Perinatal Deaths, which is to report to the County Maternal Welfare Committee, to improve the birth statistics for the newborn. Dr. Bacon then gave a complete breakdown of the 1958 statistics of the state of New Jersey.

Mr. Herbert Hill, Manager of the Bridgeton plant of the Owens-Illinois Glass Company, explained certain changes pertinent to physicians in O-I-G insurance program.

Nicholas Marchione, M.D., of Vineland, reported on the recent Constitutional Convention of The Medical Society of New Jersey, and explained the changes. Reporting on mental health, he stated that statistics on psychiatric disorders in the state of New Jersey are wanting. Steps are being taken to have all such cases recorded.

Frank Aitken, M.D., of Bridgeton, submitted his revised list of all welfare agencies and institutions in Cumberland County for use by the county members.

Benjamin Berkowitz, M.D., of Bridgeton, President-elect, gave an explanation of social security for the medical group. After the principles were explained by Dr. Berkowitz, it was stated that the members of the society would be polled individually.

Leonard G. Scott, M.D., of Bridgeton, chairman of the Public Relations Committee, reported on the Public Relations Institute recently held in Trenton. A synopsis was given of the presentations which were facets of the theme "Analyzing Our Problems." Dr. Scott's report spoke of the high ideals and the best traditions which have always distinguished good medical practitioners and stated that these traditions can be carried on so long as physicians, without exception, continue to dedicate themselves to the effort.

Morton Fuchs, M.D., Director of Diuretic Research at Hahnemann Medical College, was introduced by Pasquale A. Ruggieri, M.D., of Vineland, president of the county Heart Association. Dr. Fuchs spoke on "Clinical Aspects of Newer Diuretics in Hypertension and Heart Failure."

The meeting then adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was held on January 15.

The speaker was David Finkelstein, M.D., Assistant Professor of Cardiology, University of Pennsylvania.

Dr. Finkelstein's topic was "Arrhythmias in Everyday Practice." He discussed paroxysmal tachycardia and atrial flutter, percentage of cases, characteristics and diagnostic aids, the use of carotid sinus block, for treatment and diagnosis, digitalis, quinidine, pronestyl, and so forth.

There was a short business meeting. The treasurer reported only a few unpaid dues. There was discussion of the resolution from Bergen County Medical Society on Nursing Homes, for which our members expressed approval.

DOROTHY M. ROGERS, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by Dr. George J. Kohut, its president, February 18, at 9:00 p.m. at Oak Hills Manor, Metuchen.

Dr. Benjamin F. Slobodien, chairman of our Liability and Insurance Committee informed the members that The Medical Society of New Jersey is making available a low cost life insurance program. Dr. Sol Gurshman, representative to the

Blue Cross-Blue Shield Plan of New Jersey, informed the Society that there will be a meeting on fee schedules and payments and, if any member has a particular problem or criticism—to see him before then.

The business was adjourned and a joint social meeting of the Middlesex County Medical Society and Pharmaceutical Association then took place. Delicious cocktails and hors d'oeuvres were served followed by very humorous entertainment given by Miss Fritzi Burr, a comedienne and songstress.

DONALD T. AKEY, M.D.

Reporter

Monmouth

Dr. Charles K. Friedberg was guest speaker at the regular meeting of the *Monmouth County Medical Society* on February 25, at Fitkin Memorial Hospital. Dr. Friedberg, Cardiologist at Mt. Sinai Hospital and Associate Clinical Professor of Medicine at Columbia University, discussed "Cardiac Surgery as Viewed by the Internist." The program was sponsored by the Monmouth County Heart Association.

The business meeting was under the direction of the president, Dr. David McCreight. The annual election of officers was held with the following results: Lester A. Barnett, President; Morton F. Trippe, President-Elect; William J. D'Elia, Secretary-Treasurer; Donald W. Bowne, Assistant Secretary-Treasurer; Leonard S. Danzig, Reporter. Drs. Anthony L. Rifici, John C. Clark and Frank Niemtzow were elected members of the executive committee for a three-year period. Delegates to the State Society for a three-year term: Otto Lehmann, Howard C. Pieper, William J. D'Elia, Edith L. Brown, Francis A. Pfium and George G. Green. Alternate delegates for the same term: Charles F. Laycock, Vincent A. DelBosa, John A. Tilley, Sidney M. Hodas, Milton E. Haut and Peter J. Guthorn. Dr. George J. McDonnell was elected to the judicial committee for a five-year term. Dr. Daniel F. Featherston became nominating delegate with Dr. Louis F. Albright as alternate nominating delegate.

DONALD W. BOWNE, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on February 17, at the Medical Society Building. The president, Dr. Theodore K. Graham, presided.

Dr. Richard William Roukema of Ridgewood was elected to Active membership.

The list of nominees for election as Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey, in April, was presented. The following members were unanimously elected for a three-year term (1959-1960-1961).

Delegates—J. R. Jehl, Jack C. Warburton, Joseph E. Mott, John Scillieri, Thomas F. Reilly, Marion F. Kaletkowski, H. Hale Hollingsworth, Morris H. Saffron, James A. R. Rogers, Andrew C. Ruoff, J. Lloyd Morrow.

Alternates—William M. Sullivan, Louis Landaw, Edward A. Atwood, Solomon H. Pink, Samuel J. Della Penna, A. Hobson Davis, Samuel C. Yachnin, Frank B. Vanderbeek.

Nominating Delegate: Joseph E. Mott; Nominating Alternate: Joseph R. Jehl.

The meeting was turned over to Dr. I. Chrisman, Program Chairman, who called upon Dr. Earl Warren to introduce the first guest speaker, Mr. Albert S. Currie, Vice President and Trust Officer of the First National Bank & Trust Co., Paterson. Mr. Currie's subject was "Trusts."

The second speaker of the evening was Mr. Norman S. Brassler, Executive Vice-President of the New Jersey Bank & Trust Co. Mr. Brassler's subject was "Investment Securities."

After the conclusion of a most interesting "Banking and Investment Program," refreshments were served.

DAVID B. LEVINE, M.D.

Reporter

Salem

With Dr. Charles E. Gilpatrick, M.D., presiding, the regular monthly meeting of the *Salem County Medical Society* was held at the Du Pont-Penns Grove Country Club on February 20.

In a short business meeting the Society endorsed sponsorship of the Salem County Adult Education Advisory Council and Dr. Ford C. Spangler of Salem was appointed as a representative to that council.

The question of Social Security was again discussed and the members were polled. The secretary will announce the results at the next meeting.

Dr. John Madara reported on the proceedings of the recent meeting of the sub-committee on legislation.

Dr. George A. Nitshe introduced the first speaker for the evening, Dr. John B. Atkinson, Jefferson Medical College, and his topic was "Radiation Injuries," with special reference to the technic and effectiveness of bone marrow transplantation in treatment. Dr. Atkinson outlined the dangers involved in both uncontrollable radiation as in fallout from A bombs and in controllable radiation from x-rays.

The amount of radiation the body could withstand was discussed along with the precautions taken to protect patients from excessive x-ray radiation both during diagnostic studies and in treat-

ment of certain diseases such as cancer and leukemia.

Dr. J. Francis Mahoney, Graduate School of Medicine, continued with the discussion, pointing out the problems involved in treating these diseases and radiation injuries as seen by the x-ray specialist. The major problem is one of keeping people alive after large doses of radiation such as would be incurred from an A bomb.

Now, much time and effort is being expended in attempts to find treatments which will enable the body to withstand the effects of harmful radiation and leukemia diseases. It is hoped that further study will develop substances which when coupled with controlled radiation will materially aid in the treatment of these problems.

At the close of the meeting Dr. Gilpatrick announced that the members would be the guests of the Elmer Hospital on March 20. Dr. William A. Jeffers, of University of Pennsylvania Hospital, will be the guest speaker. He has been secured through the efforts of the Salem County Heart Association and his subject will be Hypertension and its Treatment.

G. F. REICHWEIN, M.D.

Reporter

Union

Under the chairmanship of Dr. Graham C. Newbury, its president, the *Union County Medical Society* held its regular meeting at White Laboratories, Kenilworth, on January 14.

The secretary, Dr. Charles Boozan read resolutions on the deaths of Dr. George A. Seymour and Dr. K. Hazen Scott.

Dr. Donald J. Holtzman of Elizabeth was elected to Associate membership and Dr. Thelma Golub Warshaw of Westfield was accepted for membership as a transfer from the Medical Society of the County of New York.

Following the business meeting, Dr. David Schlein, chairman of the Program Committee introduced Mr. Charles M. Ray, editor of the Cranford *Citizen and Chronicle*. Mr. Ray acted as moderator for a panel presentation entitled "What is News?" Those participating were Mr. Gregory Hewlett, editor of the Maplewood-South Orange *News-Record* and president of the New Jersey Press Association; Mr. Thomas Powers, county editor of the Elizabeth *Daily Journal;* Mr. Louis Mogelever, reporter for the Newark *Star-Ledger;* Mr. Arthur Swanson, reporter for the Newark Evening *News;* Mr. Stewart Smith, city editor of the Plainfield *Courier-News;* and Mr. Carl Hulett, editor of the Summit *Herald.*

The topics covered were "Freedom of the Press," "Names in the News," "What Constitutes News," "What the Press Wants," "Relationship Between Hospitals and the Press" and "Newspaper Policies with Regard to Malpractice Suits."

A lively discussion followed in which many of the physicians present took part. The newspaper handling of malpractice was discussed at length. It is of interest that of the newspapermen present, all stated that the present policy was to give no publicity at the time of the filing of a malpractice suit.

At the conclusion of the discussion, Mr. Richard Nevin, Executive Officer of The Medical Society of New Jersey spoke briefly. Mr. Nevin emphasized that such a meeting would lead to better relations between the medical profession and the press.

ELBERT H. POGUE, M.D.

Reporter

Society for Relief of Widows and Orphans

The Society for the Relief of Widows and Orphans of Medical Men is pleased to announce that the Trustees of The Medical Society of New Jersey have seen fit to add the Designation "WO" to the names of all members of this society in the new directory soon to be published. This will enable any of the physicians of this state to pick sponsors so that they may join the Society and take part in the relief work being done each year. It is particularly gratifying to know that the medical men of this state can and do help "our own" when they are in trouble and in difficulty. The cost is nominal—being $1 at the death of a member, the total rarely exceeding $13 a year. The next annual meeting of the Society will be held at the home of its president, Dr. Earl Leroy Wood, Newark, on May 13, 1959.

The 193rd Annual Meeting

OF

The Medical Society of New Jersey

HADDON HALL, ATLANTIC CITY

Saturday-Wednesday, April 25-29, 1959

Daily Schedule

Friday, April 24, 1959

8:00 p.m.—Board of Trustees
Bakewell Room, 1st floor

Saturday, April 25, 1959

12:00 noon—Registration Opens
Sun Porch, Lounge floor

2:30 p.m.—House of Delegates
Viking Room, 13th floor

3:30 p.m.—Golden Merit Award Ceremony
Viking Room, 13th floor

4:00 p.m.—Open Discussion on Medical-Surgical Plan
Viking Room, 13th floor

8:30 p.m.—Nominating Committee
Bakewell Room, 1st floor

Sunday, April 26, 1959

11:00 a.m.—Reference Committees:
"A"
Room 1333, 13th floor
"B"
Rooom 1344, 13th floor
"C"
Mandarin Room, 13th floor
"D"
Room 1335, 13th floor
"E"
Room 1337, 13th floor
Constitution and Bylaws
Bakewell Room, 1st floor
Miscellaneous Business
Rowsley Room, 1st floor
Resolutions and Memorials
Room 1332, 13th floor

2:30 p.m.—House of Delegates
Viking Room, 13th floor

Monday, April 27, 1959

9:00 a.m.—Exhibits Open
Lobby and Lounge floors

9:30 a.m.—House of Delegates
Viking Room, 13th floor

10:00 a.m.—Motion Picture Theatre
Card Room, Lobby floor

2:00 p.m.—Motion Picture Theatre
Card Room, Lobby floor

3:00 p.m.—General Session
Vernon Room, Lounge floor

6:00 p.m.—Dinner—New Jersey Medical Women's Association
Bakewell Room, 1st floor

9:00 p.m.—Cabaret—Music and Dancing
Rutland Room, 1st floor

Tuesday, April 28, 1959

9:00 a.m.—Board of Trustees
Bakewell Room, 1st floor

9:30 a.m.—Sections:
Obstetrics and Gynecology
Viking Room, 13th floor
Radiology
Rutland Room, 1st floor
Urology
Room 1344, 13th floor

10:00 a.m.—Sections:
Allergy
Roberts Room, Chalfonte
Anesthesiology
Solarium, Lounge floor
Chest Diseases
Mandarin Room, 13th floor
Clinical Pathology
West Room, 13th floor
Dermatology
Tower Room, 13th floor
General Practice
Garden Room, Lounge floor

10:00 a.m.—Motion Picture Theatre
Card Room, Lobby floor

10:00 a.m.—Council, New Jersey Chapter, American College of Surgeons
Room 1332, 13th floor

12:30 a.m.—Luncheons:
Section on Allergy and New Jersey Allergy Society
Rowsley Room, 1st floor
New Jersey Chapter, American College of Chest Physicians
Zodiac B, Chalfonte
Section on Dermatology
Bakewell Room, 1st floor
Section on General Practice
Parlor B, Chalfonte
Section on Radiology and Radiological Society of New Jersey
Zodiac A, Chalfonte
Section on Surgery
Wedgwood II, Lounge floor

Section on Urology
Blue Room, Chalfonte

2:00 p.m.—Section on Surgery
Viking Room, 13th floor

2:00 p.m.—Motion Picture Theatre
Card Room, Lobby floor

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge floor

Wednesday, April 29, 1959

9:30 a.m.—Sections:
Cardiovascular Diseases
Viking Room, 13th floor
Ophthalmology and Pediatrics
Garden Room, Lounge floor

10:00 a.m.—Sections:
Gastroenterology and Proctology
Mandarin Room, 1st floor
Metabolism
Rutland Room, 1st floor
Otolaryngology
Tower Room, 13th floor
Rheumatism
Solarium, Lounge floor

10:00 a.m.—Motion Picture Theatre
Card Room, Lobby floor

12:30 p.m.—Luncheons:
New Jersey Section, American College of Cardiology
Zodiac A, Chalfonte
Section on Ophthalmology, Section on Otolaryngology, and New Jersey Academy of Ophthalmology and Otolaryngology
West Room, 13th floor
Section on Rheumatism and New Jersey Rheumatism Association
Bakewell Room, 1st floor

2:00 p.m.—Section on Medicine
Viking Room, 13th floor

2:00 p.m.—Motion Picture Theatre
Card Room, Lobby floor

3:00 p.m.—Exhibits and Registration Close
Lobby and Lounge floors

Golden Merit Award Ceremony

Saturday Afternoon, April 25, 1959

Viking Room, 13th floor

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding
Kenneth E. Gardner, M.D., President

Master of Ceremonies
John F. Kustrup, M.D., Chairman, Subcommittee on Public Relations

Marshals
Presidents of component societies whose members are receiving awards

1959 Recipients

Bergen County
Charles B. Bleasby, M.D., Garfield
James B. Edwards, M.D., Leonia
Charles B. Kelley, M.D., Tenafly
Charles B. Warren, M.D., Ogdensburg, N. Y.

Burlington County
D. H. Bartine Ulmer, M.D., Moorestown

Camden County
Joseph D. Seiberling, M.D., Haddonfield

Cumberland County
Charles Butcher, M.D., Heislerville

Essex County
Thomas W. Harvey, Jr., M.D., Orange
George A. McLellan, M.D., Sparta
Sidney E. Pendexter, M.D., East Orange
Charles F. Rathgeber, M.D., East Orange

Hudson County
Harry C. Cody, M.D., Bayonne
Albert D. Greene, M.D., Union City
William W. Mayer, M.D., Jersey City

Mercer County
Nathaniel H. Koplin, M.D., Trenton
L. Samuel Sica, M.D., Trenton

Monmouth County
Ralph B. Thomas, M.D., Long Branch

Morris County
Fletcher I. Krauss, M.D., Chatham

Union County
Arthur E. Tator, M.D., Summit

General Session

Monday Afternoon, April 27, 1959

Vernon Room, Lounge floor

3:00 p.m.

Presiding
Kenneth E. Gardner, M.D., President

Inaugural Address
F. Clyde Bowers, M.D., President-Elect

Symposium
Medical Care in New Jersey—Past, Present, and Future

A panel of distinguished speakers, each an authority in his field, will discuss the subject from the point of view of (1) practicing physicians, (2) commercial insurance carriers, (3) taxpayers, and (4) popular need and demand.

Dinner-Dance

Tuesday Evening, April 28, 1959

Vernon Room, Lounge floor

7:00 p.m.

honoring

PRESIDENT AND MRS. KENNETH E. GARDNER

Toastmaster
David B. Allman, M.D.

Welcome
Mrs. A. Guy Campo, President, Woman's Auxiliary

Introductions
Mrs. George O. Rowohlt, President-Elect, Woman's Auxiliary

F. Clyde Bowers, M.D., President-Elect

Presentation of Fellow's Key
To: Kenneth E. Gardner, M.D., President
By: Lewis C. Fritts, M.D., Immediate Past-President

Guest Speaker
Louis M. Orr, M.D., President-Elect, American Medical Association

Entertainment
The Doctors' Chorus of the Essex County Medical Society

Music
Joseph Stern's Orchestra

Motion Picture Theatre

Monday, Tuesday, Wednesday—April 27, 28, 29, 1959

Card Room, Lobby floor

10:00 a.m. and 2:00 p.m.

Recognition and Management of Respiratory Acidosis

Reginald H. Smart, M.D., Hurley L. Motley, M.D., and Joseph F. Boyle, M.D.

This new teaching film presents a clinic on a topic currently gaining wide interest in the medical profession. The course of a fatal case of respiratory acidosis is illustrated and discussed by the panel. The etiology and symptoms of this condition are examined in detail and the importance of early recognition emphasized. A suggested treatment program, including emergency treatment of acute cases, is outlined fully. The use of various types of pressure breathing apparatus is demonstrated with patients. Filmed at the Cardio-Respiratory Laboratory, University of Southern California School of Medicine. (1958)

10:45 a.m. and 2:45 p.m.

Problems Relative to the Heart-Lung Machine

Cardiac Unit, Orange Memorial Hospital, Orange

This portrays the facilities considered essential for the proper function of a cardiac surgical unit, which is using open heart technic with the help of "heart-lung machine" in a community hospital. It is not enough to have a capable surgical team. It is also essential to have a team of cardiologists supported by a competent cardio-pulmonary laboratory. An animal laboratory is necessary to enable the surgical team to acquaint itself thoroughly with the new procedures as they are developed. A well equipped intensive care unit is required to carry the postoperative recovery to its successful conclusion. These facilities are demonstrated as they function at the Heart Unit of the Orange Memorial Hospital.

11:15 a.m. and 3:15 p.m.

Human Gastric Function

Stewart Wolf, M.D.

In this teaching film, Dr. Wolf, Chairman of the Department of Medicine, University of Oklahoma, reports on an experimental study of "Tom." This well-know subject had an accident in early childhood which resulted in an extensive gastric fistula. This condition allowed study of the mucosa and observation of secretory action and gastric motility under various conditions. The investigators were able to gain insight into the stomach's complex responses to different psychologic states and stresses. The film is a partial record of 15 years' continuous study of "Tom's" fistula. From 1941 to 1952 this study was carried out in collaboration with Dr. Harold G. Wolff of Cornell University Medical College. The final phases of research, from 1952 to 1956, were done in 1957 at the Oklahoma Medical Research Foundation, Oklahoma City.

Film program arranged and presented through the cooperation of Smith Kline & French Laboratories, Philadelphia, Pa.

Scientific Section Meetings

Tuesday Morning, April 28, 1959

ALLERGY

FRANK L. ROSEN, M.D., Chairman, Newark
HARRY H. HERSHEY, M.D., Secretary, Jersey City

Roberts Room, Chalfonte

10:00 a.m.

Symposium: Bronchial Asthma as an Occupational Hazard

Moderator

Frank L. Rosen, M.D., Chairman, Section on Allergy, Newark

Case Histories

Aaron Weiner, M.D., Fair Lawn; Associate Attending in Allergy, Barnert Memorial Hospital, Paterson

This presentation is based on 15 cases of bronchial asthma which won awards after formal hearings in Workmen's Compensation Court. In those with obvious allergic causes, intradermal tests and passive transfer tests confirm history and clinical course, *e.g.*, "baker's asthma." Sometimes there is an obvious allergic cause but intradermal tests are negative, *e.g.*, saw-dust sensitivity.

Inhalant irritants can "trigger" a latent allergic state or aggravate mild asthmatic symptoms.

Diagnosis is also reviewed including the use of x-rays and fluoroscopy of the chest, pertinent blood studies, and lung function tests. Also discussed are provocation tests—exposure to the responsible substance under actual conditions of employment. Histories illustrating these are given.

Pulmonary Function Tests as an Aid in Evaluating Degree of Disability

Thomas J. Ormsby, M.D., Attending Physician in Pulmonary Physiology, St. Michael's Hospital, Newark

Pulmonary function studies provide objective data useful in the resolution of medical and surgical problems associated with the respiratory tract. Numerical values developed by these studies are adaptable to the resolution of medicolegal problems in this field. The basic concepts of pulmonary physiology are reviewed and practical, specific tests quantitating respiratory defects for use in disability determination are described.

Legal Aspects

Stephen J. Lorenz, L.L.B., Supervising Deputy Director, Division of Workmen's Compensation, New Jersey State Department of Labor and Industry, Newark

This discusses the compensability of bronchial asthma as an employment-incurred condition under the New Jersey Workmen's Compensation Act. The difference between New Jersey and other states is reviewed. Also discussed are: notice to employer, statute of limitations on filing such petitions, commencement of disability, nature of proof, concept of disability, "treating" as against "examining" doctors in court, history as element of proof, successive employers, appeals: county court, Superior Court, appeal to and certification by the Supreme Court.

The Problem of Conflicting Medical Testimony

Henry A. Davidson, M.D., Past-President, Medical-Legal Society of New Jersey, Cedar Grove

There are very few absolute truths in clinical medicine. Many of our conclusions are based on opinion: generally, authoritative, well-founded opinion—but not of the same order of truth as mathematics. This is doubly true in medicolegal work. Examples of the kinds of medical testimony needed would be: Can this exposure have caused this reaction? Will this treatment help? How severely disabled is the patient? What role is played by emotional factors, what by organic factors? When can he return to work?

Some doctors naively believe that there is a right answer and an infinity of wrong answers to these queries. Let us face the fact that these are matters of opinion. Let us not scorn the doctor who disagrees with us. And certainly let us not ask for an impartial medical expert to come and testify to the One, Absolute and Only Truth. There are no such truths and there are no absolutely impartial experts. The best way to approximate truth is through vigorous cross examination.

General Discussion

11:45 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Allergy and New Jersey Allergy Society
Rowsley Room, 1st floor
Reservations: Harry Hershey, M.D.
921 Bergen Ave., Jersey City

ANESTHESIOLOGY

BERTHA P. RODGER, M.D., Chairman, Ridgewood
IRVING M. RIFFIN, M.D., Secretary, Montclair

Solarium, Lounge floor

10:00 a.m.

An Appraisal of New Induction Agents

Irving M. Riffin, M.D., Director of Anesthesia, St. Vincent's Hospital, Montclair

Co-Author: Gretl Hoch, M.D., Montclair

An appraisal of four new induction agents will be presented. One seems to be particularly fascinating in that it combines analgesic and hypnotic properties. Clinical experience was not always favorable, but the trend of researchers will be amply demonstrated. Methohexital®, Sernyl®, Doriden® injectable and G 29o5 are the compounds to be discussed and evaluated.

10:20 a.m.

The Clinical Use of Fluothane

Edward T. Lawless, M.D., Director of Anesthesia, St. Joseph Hospital, Paterson

Co-Author: Peter A. Tucci, M.D., Clifton

Clinical observations have been recorded following 400 anesthetic administrations with Fluothane®, summarizing experience with this newest of inhalation agents. Its potency makes it quick-acting and easily controllable if used so as to adhere to the fundamental physiologic principles of good ventilation, adequate oxygenation and carbon dioxide elimination. Proper concentration of the agent must not be exceeded. Its effects are quickly reversible with no lasting organic changes occurring if used in recommended precentages. Post-anesthetic recovery is rapid. Fewer postoperative sequelae were observed with Fluothane® than with other agents. The contra-indications are noted. Its extreme potency demands constant attention on the part of the anesthesiologist. Its use should be limited to those who have the experience and willingness to give this attention. Fluothane® could be the long sought-for step to the eventual elimination of all explosive agents in the operating room.

10:40 a.m.

The Biochemistry of Anesthesia

Milton Gross, Ph.D., Director, Department of Biochemistry, Margaret Hague Maternity Hospital, Jersey City

Various theories of the mechanism whereby anesthetic agents produce their effects on cellular physiology are reviewed. The earlier suggestions may all play a role in reducing the efficiency of propagation, conduction and integration of impulses in nervous tissue. Interference with metabolic activity such as oxidative phosphorylation may disrupt general cell economy. Most of the previous observations on mechanism of action of anesthetics involved isolated organ or tissue systems. It is apparent from recent studies that the entire neurophysiologic apparatus must be viewed in considering the effects of nervous system depressants.

11:05 a.m.

Concerning Nausea and Vomiting During Spinal Anesthesia

Leroy D. Vandam, M.D., Clinical Professor of Anesthesia, Harvard Medical School, Boston, Mass.

A study was made of 939 operations in which spinal anesthesia was administered by a single dose technic. This indicated that the operative incidence of nausea and vomiting was 19 per cent. Nausea and vomiting were more frequently associated with intra-abdominal and renal operations than with peripheral procedures. The precipitating factors were high sensory levels of anesthesia, experience of pain, and the onset of arterial hypotension. A thesis was developed that nausea and vomiting during spinal anesthesia were largely the result of reflex stimulation from the operative field. Prevention, therefore, requires complete blockade of sensory afferent pathways.

11:30 a.m.

Business Meeting

CHEST DISEASES

A. ALBERT CARABELLI, M.D., Chairman, Trenton
A. ABRAM PECKMAN, M.D., Secretary, Jersey City

Mandarin Room, 13th floor

10:00 a.m.

Open Heart Surgery in the Community Hospital

Alfred R. Henderson, M.D., Asbury Park; Thoracic Surgical and Cardiovascular Services, Fitkin Memorial Hospital, Neptune

The non-technical aspects of open-heart surgery in the community hospital are discussed. The feasibility and practicability of such a project, together with a discussion of many of the unpurchasable and intangible requirements of a team, are presented.

General Discussion

10:25 a.m.

The Mechanical Principles of the Heart-Lung Apparatus and Some Physiologic Aspects of Extra-Corporeal Circulation

Robert Meijer, Ph.D., Surgical Service, Fitkin Memorial Hospital, Neptune

Co-Author: Harvey Black, Neptune

This presentation describes the construction and principles of operation and control of the mechanical heart-lung apparatus now in use at the Fitkin Memorial Hospital for open-heart surgery. The advantages of hypothermia together with extracorporeal circulation are discussed. Important physiologic alteration occurring within patients and experimental animals undergoing open-heart surgery will be presented.

General Discussion

10:50 a.m.

Sarcoidosis: Clinical and Thoracic Roentgen Features

Samuel Cohen, M.D., Director of Medicine, B. S. Pollak Hospital for Chest Diseases, Jersey City

Co-Authors: Mario J. Albini, M.D., Hoboken; and David Abed, M.D., Jersey City

This is a review of 45 cases of sarcoidosis, 20 of which had histologic confirmation. Forty are living as of September 1958. The length of follow-up in the living cases varied from a few months to 18 years. The remaining 5 patients died. Survival in these patients ranged from 2 to 9 years. The clinical and laboratory findings are commented upon. An attempt is made to classify the chest x-ray findings at the time the diagnosis was first made. The subsequent roentgenologic course is presented. Reference is made also to prognosis, causes of death and steroid therapy.

General Discussion

11:15 a.m.

The Endoscopic Therapy of Parenchymal Tuberculosis

A. Albert Carabelli, M.D., Attending in Thoracic Medicine, St. Francis Hospital, Trenton

For the past five years the author has been conducting a pilot experiment on pulmonary tuberculosis. The series studied includes early as well as far-advanced cavitational types of lesions. The special technic for the recovery of tubercle bacilli permits finding them much earlier than can be done by sputa or gastric search. The positive yield is greater. False negatives are obviated. A special bacillus collector (designed by the author) is used endobronchially for this purpose. The technic consists of the introduction into the diseased segment or lobe of isonicotinic acid hydrazide in special preparation. Emphasis is placed on upper lobe disease. Instillation of the antibiotic is facilitated by the use of a special optical bronchoscope (designed by the author) so that this is conducted under direct vision. Since this bronchoscope permits visualization in all five lobes, it has been called the "Pentascope." Results of this therapy in tuberculosis are striking with restitution to normal of the diseased parenchyma within a matter of weeks with concomitant conversion of secretions. Lapse of sufficient time indicates that the resolution of the parenchymal lesions is permanent and not transient.

General Discussion

11:40 a.m.

Business Meeting

12:30 p.m.

Luncheon—New Jersey Chapter, American College of Chest Physicians

Zodiac B, Chalfonte

Reservations: Emanuel Klosk, M.D.
46 Lyons Avenue, Newark

CLINICAL PATHOLOGY

Milton Ackerman, M.D., Chairman, Atlantic City
Jacob Churg, M.D., Secretary, Teaneck

West Room, 13th floor

10:00 a.m.

Jaundice: Basic Science Conference

Moderator

Hans Popper, M.D., Director of Department of Pathology, The Mt. Sinai Hospital, New York, N. Y.

Panelists

Fenton Schaffner, M.D., Research Associate in Gastroenterology, The Mt. Sinai Hospital, New York, N. Y.

Myra Zinke, M.D., Matawan; Department of Medicine, Seton Hall College of Medicine and Dentistry, Jersey City

Samuel Diener, M.D., Associate Attending Surgeon, Newark Beth Israel Hospital, Newark

Two cases of jaundice will be presented and discussed. Both patients received drugs capable of producing jaundice. One patient died, the other patient was surgically explored.

The following points will be touched upon in the discussion:

a. Differential diagnosis of jaundice—clinical and laboratory
b. Surgical indications in jaundice
c. Pathology of jaundice
d. Management of jaundice
e. Electrolyte problems in surgical management of jaundice.

11:00 a.m.

Clinicopathologic Conference

Panelists

Charles L. Brown, M.D., Dean, Seton Hall College of Medicine and Dentistry, Jersey City

Frank W. Konzelmann, M.D., Director of Laboratories, Shore Memorial Hospital, Somers Point

A 39-year old woman was admitted suffering from shortness of breath; productive cough and fatigue, all of 3 months' duration. A dram or two of sputum was produced per day. It was yellow and mucoid. Tuberculosis Patch Tests were negative. Symptoms grew progressively worse. Temperature and pulse rose. She became dyspneic, coughing frequently. Pharynx was injected. She died 3 months after admission. X-ray showed diffuse infiltration of both upper lobes with questionable masses in upper mediastinum. The sputum was consistently negative for tubercle bacilli. We failed to demonstrate elevation globulin at the expense of serum albumin.

11:45 a.m.

Business Meeting

DERMATOLOGY

Everitt V. Dulin, M.D., Chairman, East Orange
Eva T. Brodkin, M.D., Secretary, Newark

Tower Room, 13th floor

10:00 a.m.

Pruritis

Joseph E. Higi, M.D., East Orange; Associate Attending Dermatologist, Orange Memorial Hospital, Orange

ACTH and cortisone derivatives are the most effective drugs available for the symptomatic treatment of the itch, but—as will be pointed out in the paper—there are limitations to their use. Naturally, a removal of the cause should be the prime object of therapy. Sometimes psychotherapy is effective. The sensorium may be dulled, and thus the itch alleviated by giving sedatives, antihistaminics, hypnotics and tranquilizers. Acute conditions may justify wet packs and colloidal baths; chronic and dry types of dermatitis may justify creams and ointments.

10:20 a.m.

Dermatologic Surgery

George C. Andrews, M.D., Professor, Dermatology and Syphilology, Columbia University College of Physicians and Surgeons, New York, N. Y.

Most skin lesions which require excision, are handled through simple operations under local anesthesia. This paper describes, however, forms of minor skin surgery which should be undertaken only by dermatologists who have had adequate surgical training. They should possess an autoclave, drapes, gloves, and small instruments such as are used in eye surgery as well as a few larger instruments. Xanthelasma, chondrodermatitis nodularis helicis, sebaceous and keratinous cysts, epitheliomas, leukoplakia, and some pigmented or verrucous nevi illustrate the variety of conditions that may be excised surgically. In addition, furuncles, carbuncles, and simple pustules may require incision and drainage. Patients with carbuncles should usually have a general anesthetic and be hospitalized. Dermabrasion or skin planing is a form of surgical treatment for pitted scars of the face from acne or other causes. Technical details, indications and contra-indications will be discussed. Conservatism and the help of a cancer surgeon or plastic surgeon when necessary are recommended.

10:45 a.m.

Experience with Grenz Radiation in the Treatment of Hemangiomas

Edward E. Shapiro, M.D., Attending Dermatologist, Bayonne Hospital and Dispensary, Bayonne

Ninety-eight infants with superficial and cavernous hemangiomas were treated with Grenz radiation over a five-year period. An attempt will be made to evaluate this form of treatment in contrast with other modalities used. In addition, a comparison of the effects of treatment with the age of the patient at onset of therapy will be made. Ektachrome® slides demonstrating the course of resolution and final results will be shown.

11:05 a.m.

Focal Infection in Dermatology

Charles F. Post, M.D., Associate Dermatologist, The Valley Hospital, Ridgewood

Co-Author: Edward W. Jewell, M.D., Ridgewood

Wide differences of opinion exist concerning the importance of foci of infection and the relationship of such foci to certain diseases of the skin. When ill-defined syndromes and diseases of unknown etiology are treated by indiscriminate surgical pro-

cedures, understandable disbelief in the entire focal infection theory naturally results.

Careful studies over a period of years, however, reveal the importance of focal infection in a few diseases of the skin such as acne vulgaris, pustular rosacea, pustular bacterid, urticaria, and occasionally some others. This paper will present evidence and statistics that show the importance of focal infection in certain dermatologic diseases. Dental x-rays and clinical photographs will also be shown.

11:25 a.m.

Discussion

11:45 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Dermatology
Bakewell Room, 1st floor

Reservations: Everitt V. Dulin, M.D.
144 S. Harrison Street, East Orange

GENERAL PRACTICE

Robert E. Verdon, M.D., Chairman, Cliffside Park
Louis Kosminsky, M.D., Secretary, West New York

Garden Room, Lounge floor

10:00 a.m.

The Use of Hypnosis in Obstetrics

Milton Jabush, M.D., President, New Jersey Society for Clinical and Experimental Hypnosis

Discussor: Francis J. Primich, M.D., Weehawken

In response to numerous inquiries from physicians concerning the effectiveness of hypnosis as applied to medicine and dentistry, the American Medical Association, through its Council on Mental Health, undertook a two-year investigation. The Council issued a report which stated, in part, that there is a proper place for hypnosis in medicine and dentistry. It emphasized that the clinical application of hypnotic technics should be within a general framework of dynamic psychology.

In this paper the author discusses a method of group conditioning for obstetrical delivery under hypnosis. He elaborates on some of the concepts involved in the selection of the patient for hypnotic conditioning. A few induction technics are discussed. Two case reports are discussed: (1) the utilization of deep hypnosis to abort premature contractions; (2) the employment of hypnosis to induce active labor.

10:30 a.m.

Hypnosis in General Practice

Abraham Weinberg, M.D., Department of Anesthesiology, Lincoln Hospital, New York, N. Y.

Discussor: Louis Kosminsky, M.D., West New York

General practice can easily become the dominant area in medicine for the utilization of the hypnotic technics. Hypnotic procedures can be made available for diagnostic, therapeutic, and prophylactic purposes. There is no field in medicine where necessary rapport is so readily established as in general practice. Here hypnosis can be used for the relief of stress and anxiety, alleviation of distress by reassurance, intensifying motivation for rehabilitation and improvement through relaxation, for pain control, removal of fear and tension, and for supportive surgery. Hypnosis, where indicated, can be a useful tool in the kit of the general practitioner.

11:00 a.m.

Medical Hypnosis, Its Use and Abuse (illustrated)

Jacob H. Conn, M.D., Assistant Professor of Psychiatry, Johns Hopkins University School of Medicine, Baltimore, Md.

In selected cases, hypnosis can be used to foster relaxation, to alleviate anxiety, to relieve pain, and to recapture repressed, significant memories. *Any physician can learn how to hypnotize.* The art of hypnotizing, like the art of medicine, consists not only of learning what procedure to use, but when to use it, how much to do, and when not to use it.

In selected cases hypnosis can be used to relieve pain in cancer, in severe burns and in minor and major surgery. It is helpful in reducing anxiety in dental care and obstetrics. It has been reported as valuable in the treatment of habituation, obesity, stuttering, and skin disorders. Hypnosis was developed by doctors to help patients; it belongs in the armamentarium of every practitioner.

Discussion

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on General Practice
Parlor B, Chalfonte

Reservations: Robert E. Verdon, M.D.
576 Anderson Ave., Cliffside Park

OBSTETRICS AND GYNECOLOGY

Rudolph C. Schretzmann, M.D., Chairman, Hackensack

Edward A. Y. Schellenger, M.D., Secretary, Camden

Viking Room, 13th floor

9:30 a.m.

Symposium: The Prevention of Perinatal Loss

Moderator

Rudolph C. Schretzmann, M.D., Chairman, Section on Obstetrics and Gynecology, Hackensack

Pathology, Prevention, and Treatment of Abortions

Arthur V. Greeley, M.D., Associate in Obstetrics and Gynecology, New York Lying-In Hospital, New York, N. Y.

Discussor: Earl B. Keller, Jr., M.D., Camden

Spontaneous abortion ranks with heart disease and cancer as a leading cause of death. Emotional determinants play a major role in the cause of this condition. Our goal should be the prophylaxis and prevention of threatened abortion and therefore habitual abortion.

A radical change is advocated for the treatment of threatened abortion. Results here presented seem to indicate a measure of success.

Prevention of Premature Births and Fetal Anoxia

Robert E. Nesbitt, Jr., M.D., Professor of Obstetrics and Gynecology, Albany Medical College, Albany, N. Y.

Discussor: John L. Gaines, M.D., Camden

The current concept of obstetrical care has as its principal objective the correction of "faulty maternal environment" prior to and following conception. Only a minority of obstetrical patients achieve "optimal" or "basic" perinatal salvage because the majority have factors which increase the risk of perinatal mortality or morbidity. These factors must be summated in deciding on definitive methods of management. Avoidance of multiple insults to the fetal respiratory center, including minimizing hypoxia, trauma and narcosis, should be the primary objective. Certain medical and surgical advances have made it possible for many patients under therapy to proceed further in pregnancy than formerly without increasing jeopardy to the mother. In most instances, the longer the fetus can remain in the uterus, the better are its chances of extra-uterine survival.

Prevention of Fetal Birth Trauma

Joseph P. Donnelly, M.D., Medical Director, Margaret Hague Maternity Hospital, Jersey City

Discussor: Herbert H. Eccleston, M.D., Hackensack

This presentation discusses the avoidance of fetal birth trauma by the elimination of difficult breech extractions, traumatic mid forceps deliveries, and versions. The use of so-called "trial forceps" in cases of questionable cephalopelvic disproportion will be suggested. Also considered is the prevention of fetal trauma to prematures by routine episiotomy and low forceps delivery under local or spinal anesthesia.

Several other conditions which frequently cause trauma in the newborn will also be discussed.

11:45 a.m.

Business Meeting

RADIOLOGY

Stephen B. Dewing, M.D., Chairman, Flemington

C. Richard Weinberg, M.D., Secretary, Newark

Rutland Room, 1st floor

9:30 a.m.

Influence of Hemic, Circulatory, and Neurogenic Factors on Bone Mineralization

Nicholas G. Demy, M.D., Plainfield; Chief of Radiology, Somerset Hospital, Somerville

Radiographic bone density reflects the deposition and removal of the minerals which give bone its characteristic density under the influence of circulating metabolites, toxins, tumor and bacterial emboli, hormones and enzymes; of the hematopoietic state and demands; of inflammatory response; of the neurogenic factors which control either muscle tone or blood flow as a reaction to injury.

The hallmark of hyperemia is demineralization; of ischemia it is mineral condensation. So-called "disuse atrophy" is a stale term which tells us nothing of the physiologic response the bone makes to injury, inflammation, and systemic disease outside of bone.

The presentation is radiologic with a lift from physiology and pathology.

10:10 a.m.

Significance of Altered Dynamics in Cerebral Angiography

Philip J. Hodes, M.D., Professor of Radiology, and Chairman, Department of Radiology, Jefferson Medical College Hospital, Philadelphia, Pa.

Cerebral angiography is used with increasing frequency in an increasing number of conditions. The availabilty of less toxic dyes plus the increased experiences of numerous physicians in injecting the common carotid artery has made this diagnostic modality almost routine. It has been given added impetus by the fact that there are an increasing number of cerebral diseases which can be treated successfully if the diagnosis is appreciated early enough. Among these may be included cerebral thrombosis, infarction, and hemorrhage of various origin.

In this presentation, Dr. Hodes touches on less commonly appreciated cerebral angiography findings which are of considerable importance in the recognition of intracranial disease.

10:35 a.m.

Management of Carcinoma of the Cervix Uteri—Problem Cases

Rieva Rosh, M.D., Assistant Professor of Radiology, New York University College of Medicine, New York, N. Y.

The author will draw on her long and wide experience in the treatment of uterine carcinoma with radium. Rather than discuss standard technics, she will describe the management of cases presenting a variety of common and uncommon anatomic problems such as distorted cervical stumps, obliterated fornices, and extention of tumor along the vaginal wall.

11:10 a.m.

Interpretation of Chest Films in the Neonatal Period

Sheldon Fox, M.D., Elizabeth

Ordinary equipment easily provides sharp x-ray photographs of the infant chest. Major difficulties are due to (1) positioning and (2) respiratory timing. These may simulate or conceal aeration changes encountered in the early months.

Hyalin membrane disease, obstructive aspiration, and bronchiolitis are usually accompanied by atelectasis or emphysema. Complicating pneumatocele, pneumothorax or mediastinal emphysema are seen infrequently.

Obstruction is usually inconspicuous in the primary pneumonias. Gross pleural effusion arouses suspicion of staphylococcal pneumonia, later fortified by the appearance of air pockets.

Occasionally prenatal disorders, such as diaphragmatic hernia, tracheo-esophageal atresia, phrenic birth palsy, or cardiovascular malformation, are discovered.

11:40 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Radiology and Radiological Society of New Jersey

Zodiac A, Chalfonte

Reservations: Andrew P. Dedick, Jr., M.D. 67 E. Front Street, Red Bank

UROLOGY

Ralph J. Veenema, M.D., Chairman, Ridgewood
Reginald F. Seidel, M.D., Secretary, Englewood

Room 1344, 13th floor

9:30 a.m.

Endoscopic Surgery in Bladder Tumors

Ralph C. Yeaw, M.D., Director of Urology, St. Joseph Hospital, Paterson

Discussor: John K. deVries, M.D., Summit

This paper reviews recent, pertinent literature. It includes a statistical review of results of endoscopic resection of bladder tumors at St. Joseph Hospital in Paterson, N. J. Certain technical problems and complications will be discussed. No attempt will be made to compare this method, statistically, with other methods of treatment of bladder tumor.

10:00 a.m.

Endoscopic Resection of the Prostate and Adaptation of Its Technic to Transvesical Prostatectomy

Stanley I. Glickman, M.D., Associate Urologist, Mt. Sinai Hospital, New York, N. Y.

Discussor: Edward A. Brady, Jr., M.D., New Brunswick

10:40 a.m.

Hemostasis in Retropubic Prostatectomy

Anthony R. Fernicola, M.D., Attending Urologist, Columbus Hospital, Newark

Discussors: Francis P. Twinem, M.D., Hackensack, and Kenneth L. Day, M.D., Summit

Ten years have elapsed since Millin's introduction of retropubic prostatectomy to the American urologist. Early enthusiasm for it waned as a result of numerous complications. Proponents of

retropubic prostatectomy have demonstrated that these complications are distinctly infrequent. However, one complication that is reported to prevail is operative blood loss.

In a series of 76 consecutive retropubic prostatectomies performed by the author in one hospital not a single blood transfusion was required.

The surgical significance of the vascular topography encountered in retropubic prostatectomy is illustrated. The operative technic for accomplishing effective hemostasis is described.

This method of prostatectomy affords short duration of operating time, catheter drainage and hospitalization. Other assets are early ambulation, a benign postoperative course and good functional results. Effective hemostasis with minimal blood loss is an outstanding attribute of retropubic prostatectomy.

11:10 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Urology
Blue Room, Chalfonte

Reservations: Ralph J. Veenema, M.D.
123 Prospect St., Ridgewood

SURGERY

James H. Spencer, M.D., Chairman, Newton
Paul Mecray, Jr., M.D., Secretary, Camden

Viking Room, 13th floor

12:30 p.m.

Luncheon—Section on Surgery
Wedgwood H, Lounge floor

Reservations: Sherman Garrison, Jr., M.D.
108 West Commerce St., Bridgeton

2:00 p.m.

Pre-Operative Evaluation and Medication

Loftus Hengeveld, Jr., M.D., Hohokus: Attending Anesthesiologist, Hackensack Hospital, Hackensack

This presentation offers a general dissertation on some of the pitfalls encountered in pre-operative evaluation and medication for patients being prepared for surgery.

2:20 p.m.

Inguinal Hernia

Roswell K. Brown, M.D., Associate Clinical Professor of Surgery, University of Buffalo School of Medicine, Buffalo, N. Y.

The modern hernia operation dates from Bassini's innovation in 1887: opening the inguinal canal, ligating the sac at the deep inguinal ring, and restoring the obliquity of the canal. Essential and optional details of the operation are illustrated.

Warnings are given against: attempts at manual reduction of strangulated hernias, extensive search for a freed loop which has slipped out of the operator's view, leaving adjacent or contralateral hernias undiagnosed and unrepaired, injuring the vessels of the spermatic cord.

Results of the operation are excellent in all ages including premature infancy and advanced senility.

2:45 p.m.

Results of Aspiration Biopsy of Breast Tumors

Frank M. Mastroianni, M.D., Associate Attending Surgeon, Malignant and Allied Diseases, Elizabeth General Hospital, Elizabeth

Given an accessible mass free of vital structures, aspiration biopsy is easy to perform, affords rapid diagnosis of acceptable accuracy, has wide applicability, allows preplanning of definitive surgical procedures, results in considerable economy to the physician and patient and, where used as an office procedure, results in a decrease in hospitalizations.

Objections levelled at the technic are largely unfounded. These objections are: (1) Difficulty and danger of performance; (2) Inaccuracy; (3) False sense of security with negative reports and (4) Implantation of malignant cells along the needle tract.

3:05 p.m.

Business Meeting

3:20 p.m.

The Evaluation of Reconstructive Vaginal Plastic Surgery in Relation to Its History and Development

Inglis F. Frost, M.D., Morristown; Consulting Obstetrician and Gynecologist, Woman's Hospital Division, St. Luke's Hospital, New York, N. Y.

Reconstructive vaginal plastic surgery has been practiced for 140 years. Surgical procedure for the cure of cystocele, retocele and uterine prolapse has been slow to develop. The first vaginal hysterectomy was done by Sauter in 1822 for a carcinomatous uterus. Thirty-nine years later, Choppin succeeded in the removal of a uterus for procedentia.

Sims in 1849 successfully closed a vesico-vaginal fistula by the use of silver wire.

In this country and Germany, flap splitting with mobilization of the bladder became the common procedure in vaginal plastic work, whereas in England, denudation of the anterior and posterior vaginal walls with removal of the cervix became the accepted practice.

Knowledge of the vagina to its adjacent organs, both in their normal and abnormal relationships, is necessary in securing a satisfactory surgical result.

CARDIOVASCULAR DISEASES

Sidney R. Arbeit, M.D., Chairman, Jersey City
Mortimer L. Schwartz, M.D., Secretary, Irvington

Viking Room, 13th floor

9:30 a.m.

Factors Affecting the Incidence and Prognosis of Cardiovascular Disease Among Physicians

Norman Reitman, M.D., Director of Medicine, Middlesex General Hospital, New Brunswick

This paper stresses the physical, socio-economic, and emotional factors which play a part in the development of cardiovascular diseases among physicians in New Jersey. It has long been felt that physicians have a particularly high incidence of cardiovascular disease—coronary, hypertension, and cerebral accidents; but, from the figures available it appears that the incidence is no higher than for the general population.

The study will break down types of practices and correlate them against stress and physical effort to see if any correlation exists with the rate of cardiovascular disease. These figures will also be discussed in relation to the mortality figures as found by the insurance companies and the general mortality figures as seen throughout the country through the U. S. Public Health Service.

The factors of weight and diet will be studied in relation to the incidence and prognosis of cardiovascular disease among the medical profession.

9:50 a.m.

Symposium: Which of Your Patients Can Now Be Benefited by Cardiac Surgery?

Surgery for Coronary Artery Disease—Indications and Results

Nicholas A. Antonius, M.D., Director, Department of Cardiology, St. Michael's Hospital, Newark

Clinical Selection of Rheumatic Heart Disease and Congenital Heart Disease Patients for Surgery

Harry Gross, M.D., Assistant Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

Confirmatory Laboratory Findings

Albert B. Sarewitz, M.D., South Orange; Assistant Attending Physician, Orange Memorial Hospital, Orange

Continuing spectacular advances in cardiac surgery make outmoded even last year's criteria for operability of the heart. Three panelists will discuss the clinical implications of these advances. The first will present current views on the selection of patients with coronary artery disease who may be expected to be benefited by the presently available surgical procedures.

The second paper will be concerned with the clinical selection of patients for cardiac surgery. Indications based on murmurs, electrocardiograms, x-rays and other modalities will be discussed in their relation to rheumatic and congenital heart disease. Particular emphasis will be placed on diagnostic procedures that lead to a more precise diagnosis and indicate which patients should be operated now and which should be deferred until better technics are available.

The third speaker will review the laboratory procedures and findings usually elicited pre-operatively to confirm the diagnoses and indicate the type of surgical procedure likely to yield the best clinical results.

There will be no formal discussors of this symposium. Twenty minutes will be reserved at the end of the symposium for questions from the floor.

11:20 a.m.

The Usual and the Unusual Electrocardiographic Patterns in Myocardial Infarction

Ira L. Rubin, M.D., Attending Cardiologist, Morrisania City Hospital, New York, N. Y.

In the typical myocardial infarction, there are characteristic electrocardiographic changes. These include initial elevation of the ST segment, T wave inversion and the development of abnormal Q waves. Following the initial changes, the ST segment becomes isoelectric and the T wave may or may not revert to normal. From no single tracing can the diagnosis of acute infarction be made. A typical clinical course and typical laboratory changes can establish the diagnosis of myocardial infarction in the absence of characteristic electrocardiographic changes.

The myocardial infarction can be fairly well localized by the electrocardiographic changes. Various electrocardiographic abnormalities are presented. Difficulties in differentiating a normal, bor-

derline and abnormal Q wave in Leads AVF and Lead 3 and the differentiation of pulmonary embolus and posterior wall myocardial infarction secondary to this change will be reviewed, as will the development of right or left bundle branch block and their relation to an acute infarct. Isolated T wave changes, and T wave changes associated with ST depression, will be discussed in relation to the differential diagnosis between coronary insufficiency, anginal syndrome and subendocardial infarction. Electrocardiographic patterns mimicking myocardial infarction caused by normal rotational changes or dilatation of one of the chambers of the heart must be differentiated from this disease.

11:45 a.m.

Business Meeting

12:30 p.m.

Luncheon—New Jersey Section, American College of Cardiology

Zodiac A, Chalfonte

Reservations: Arthur Bernstein, M.D. 668 Clinton Avenue, Newark

GASTROENTEROLOGY AND PROCTOLOGY

Irving G. Larkey, M.D., Chairman, Irvington

Herbert B. Silberner, M.D., Secretary, Newark

Mandarin Room, 13th floor

10:00 a.m.

Symposium: Diarrhea

Chairman

Irving G. Larkey, M.D., Chairman, Section on Gastroenterology and Proctology, Newark

Diagnostic Approach

Samuel M. Gilbert, M.D., Associate in Medicine, Newark Beth Israel Hospital, Newark

The commonest cause of chronic diarrhea in this locality is the spastic or irritable or sensitive colon. The next two in frequency are ulcerative colitis and carcinoma of the bowel. A complete examination is essential in every case to rule out organic pathology before a diagnosis of spastic colon can be made.

Radiologic Aspects

Jacob A. Riese, M.D., West New York; Attending Gastroenterologist, Medical Center, Jersey City

Often there is no x-ray evidence to substantiate a diagnosis for an existing diarrhea. But there still remain a group of syndromes in which definite organic pathology leads to changes evident on the x-ray film. Conditions which most commonly give roentgen evidence of disease include: (1) ileitis; (2) sprue, pancreatitis, malnutrition syndromes; (3) ulcerative colitis, specific and non-specific; (4) carcinoma of small or large intestine; (5) postoperative complications.

Parasitic Diseases

Samuel W. Eisenberg, M.D., Assistant Professor of Proctology, and Assistant Professor of Parasitology, Temple University School of Medicine, Philadelphia, Pa.

The parasitic infections responsible for diarrheas will be discussed, together with a classification of the parasites inhabiting the human digestive tract. Practical methods, and principles of diagnosis will be indicated, as well as specific therapy of important intestinal parasitoses. The recent increase in intestinal parasitic infections in this country makes this an important and timely subject.

Clinical Aspects

William Z. Fradkin, M.D., Attending Physician, Adelphi Hospital, Brooklyn, N. Y.

The treatment of a diarrhea requires a genuinely sympathetic approach to the patient, the elimination of all etiologic factors, detection and correction of nutritional deficiencies, neutralization of the infections, toxic and emotional state by the judicious and careful use of chemotherapy, antibiotics, sedatives and corticosteroid hormones.

Discussor: Andrew J. V. Klein, M.D., Newark

11:45 a.m.

Business Meeting

METABOLISM

J. John Kristal, M.D., Chairman, Hackensack
George A. Hess, M.D., Secretary, Trenton

Rutland Room, 1st floor

10:00 a.m.

The Value of Blood Ammonium Assay in Disease

Vincent H. Gillson, M.D., Pathologist and Director of Laboratories, Bergen Pines Hospital, Paramus

In the mammalian organism, the production of ammonia in the intestinal tract by the proteolytic enzymes of the coliform bacteria is the major natural source of blood ammonium. This is reflected by the relatively high concentrations in the portal circulation. Its deamination by the healthy liver affords adequate protection from the serious consequences of hyper ammoniemic intoxication.

Compromised in this vital function, the diseased liver permits an accumulation of ammonia within the general circulation. This is especially true when such added burdens are imposed as gastrointestinal hemorrhage or exogenous ammonium chloride.

The quantitation of the blood (arterial) ammonium is not technically difficult and yet can frequently offer the physician effective help in the diagnosis and intelligent therapeusis of some of the gravest symptoms of hepatic disease.

Discussion

10:25 a.m.

Neuropathy of the Lower Extremity in the Diabetic

John C. Hoover, M.D., Associate Attending in Orthopedic Surgery, Hackensack Hospital, Hackensack

Co-Author: Harry Merliss, M.D., Hackensack

Discussion

10:50 a.m.

The Usefulness of Plasma Steroid Determinations in Diagnosis

Nicholas P. Christy, M.D., Associate in Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

In assessment of adrenal cortical disease, values for urinary steroids have been useful guides, but are subject to error through difficulties in collection and through effects of hepatic metabolism and renal excretion. Plasma 17-hydroxycorticosteroid levels (which measure chiefly hydrocortisone) have often proved more reliable indices of adrenal cortical function, especially when steroid response to ACTH has been tested in a standard manner. Normal levels (4-20 micrograms per cent) rise to 35-55 after 4-hour intravenous infusion of 25 units ACTH. In Addison's disease, levels are usually subnormal and do not rise after ACTH. In contrast, values in hypopituitarism and after prolonged steroid therapy rise in response to ACTH, but rise is subnormal. In Cushing's syndrome (bilateral adrenal hyperplasia) steroid values rise as high as 85 micrograms per cent after ACTH, while response in cases of adrenal tumor is usually minimal.

Discussion

11:20 a.m.

Recent Work with Insulin and Glucagon

James M. Salter, Ph.D., Assistant Professor, Banting and Best Department of Medical Research, University of Toronto, Toronto, Canada

Insulin in addition to influencing carbohydrate metabolism, exerts a marked effect on growth and protein synthesis. Insulin administered to hypophysectomized animals decreases nitrogen excretion, stimulates appetite and weight gain. The increase in weight is due to the synthesis of protein as well as fat and is accompanied by an increased rate of skeletal growth. Many actions of insulin are antagonized by glucagon, a hormone believed to be manufactured by the alpha cells of the islets of Langerhans. Glucagon is present in the blood of normal animals but its physiologic significance remains speculative. Under experimental conditions the administration of glucagon to many species, including man-produced hyperglycemia, glucosuria, ketonuria, a negative nitrogen balance, raises the metabolic rate and greatly suppresses some inflammatory processes.

Discussion

11:50 a.m.

Business Meeting

OPHTHALMOLOGY AND PEDIATRICS

Joint Meeting

Ophthalmology

CHARLES E. JAECKLE, M.D., Chairman, East Orange

JAY E. MISHLER, M.D., Secretary, Atlantic City

Pediatrics

MILTON M. WILLNER, M.D., Chairman, Newark

SAMUEL C. SOUTHARD, M.D., Secretary, Ventnor

Garden Room, Lounge floor

9:30 a.m.

Symposium: Certain Aspects of Eye Care in Children

Ocular Examination of the Child

Alfonse A. Cinotti, M.D., Attending Ophthalmologist, Medical Center, Jersey City

It is not feasible at present for all children to have periodic, complete eye examinations. Screening for ocular defects is, therefore necessary. The pediatrician must share a large part of the responsibility in seeing that such screening is accomplished.

The primary objective of screening is the detection of suppression amblyopia and of major refractive errors. This paper presents a general review of technics and standards requisite for an effective screening program in infants, pre-school and school children.

Surgical Treatment of Ptosis

Raynold N. Berke, M.D., Hackensack; Assistant Clinical Professor of Ophthalmology, Columbia University College of Physicians and Surgeons, New York, N. Y.

Blepharoptosis in children is nearly always congenital. The usual cause is an anatomic failure of development of the levator palpebrae muscle.

The treatment of choice is resection of the levator muscle. The operation should be done when the child is old enough to cooperate, preferably between three and one-half and four and one-half years of age.

Ocular Factors in Retarded Reading

Hunter H. Romaine, M.D., Clinical Professor of Ophthalmology, New York University Postgraduate School of Medicine, New York, N. Y.

Ocular factors concerned in reading retardation are of importance in an understanding of the overall pattern of this problem. The eyes are usually only a small part of the entire picture. Factors which are of significance include: visual acuity, muscular anomalies of small and large degree, systemic disease affecting the eyes and unusual patterns related to the accommodative system.

A classification of reading disabilities and the place of the ophthalmic difficulties and also the place of the ophthalmologist in this process will be discussed.

Management of Strabismus in Children

Harold W. Brown, M.D., Clinical Professor of Ophthalmology, New York University Postgraduate School of Medicine, New York, N. Y.

The successful management of strabismus is, in a large measure, dependent on early treatment.

The pediatrician is often the first one to detect or be consulted about an ocular motor defect in children. To advise the parents of such patients, he should be aware of the handicaps, and the basic factors of the cause and treatment of strabismus.

Early correction of refractive errors and early occlusion for the treatment of amblyopia ex anopsia are essential in the non-operative treatment of strabismus. If non-operative treatment fails to correct an evident deviation in a reasonable length of time, surgery is usually indicated.

General Discussion

Moderator

Charles E. Jaeckle, M.D., Chairman, Section on Ophthalmology, East Orange

11:45 a.m.

Business Meeting

12:30 p.m.

Joint Luncheon- Section on Ophthalmology, Section on Otolaryngology, and New Jersey Academy of Ophthalmology and Otolaryngology

West Room, 13th floor

Reservations: Jay E. Mishler, M.D.
1616 Pacific Ave., Atlantic City

OTOLARYNGOLOGY

CHARLES E. LANGGAARD, M.D., Chairman, Summit
JOSEPH R. BURNS, M.D., Secretary, Trenton

Tower Room, 13th floor

10:00 a.m.

The Widening Scope of Tracheotomy

Aris M. Sophocles, M.D., Trenton; Ear, Nose and Throat Service, University of Pennsylvania Hospital, Philadelphia, Pa.

Co-Author: Joseph B. Atkins, M.D., Philadelphia, Pa.

At the University of Pennsylvania, about 400 tracheotomies were carried out in the last four years. One hundred and fifty were done on laryngeal tumors where creation of an airway was clearly a matter of necessity. In 250 cases the indications bring out a widening and more planned application. Prevention of lower respiratory obstruction is an ever present challenge whether encountered in a postoperative patient or in a medical patient. Secretions will lead to obstruction, infection, atelectasis and systemic complications unless relief is given in time.

10:20 a.m.

Surgical Correction of Caudal Septal Deformities

Irvin J. Fine, M.D., Director, Head and Neck Department, Perth Amboy General Hospital, Perth Amboy

A procedure is described for correction of the caudal deviated septum, based on the principle of mobilization of the caudal end to the midline by vitalized pedicle septal flaps of caudal deflection and central replacement of deviated posterior osseocartilaginous parts. The objective of the operation is the restoration of normal anatomic relations of the deflected septum with minimal sacrifice of its structures.

10:40 a.m.

Experiences in Head and Neck Surgery

Edgar P. Cardwell, M.D., Attending Otolaryngologist, Martland Medical Center, Newark

This is a preliminary report of the activity of the head and neck service of the Black-Stevenson Tumor Clinic in the United Hospital of Newark, Presbyterian Unit. The presentation is given with the aid of color slides. An effort will be made to show lower morbidity in malignant tumors of the air and food passages.

11:00 a.m.

Practical Office Audiology and Labyrinth Tests

Lee R. Stoner, M.D., Associate Clinical Professor, State University of New York College of Medicine, Syracuse, N. Y.

With all the research studies now being made on the physiology of hearing and the pathology of deafness, both theoretical and applied, the clinical otolaryngologist must sometimes feel terribly inadequate in his methods for testing hearing and labyrinthine function.

This feeling may be deserved if we fail to keep pace with new trends in audiology. However, methods are available to all of us in office practice which will ordinarily help us to reach a reasonably accurate diagnosis for the hard of hearing patient. This presentation will deal with such methods.

11:25 a.m.

Business Meeting

11:40 a.m.

Film—Elective Rhinoplasty

Produced by Irving B. Goldman, M.D., Chief, Department of Rhinoplasty, Mt. Sinai Hospital, New York, N. Y.

12:30 p.m.

Joint Luncheon—Section on Otolaryngology, Section on Ophthalmology, and New Jersey Academy of Ophthalmology and Otolaryngology

West Room, 13th floor

Reservations: Jay E. Mishler, M.D.
1616 Pacific Ave., Atlantic City

RHEUMATISM

CLARENCE B. WHIMS, M.D., Chairman, Ventnor
GEORGIA E. ALLEN, M.D., Secretary, Haddon Heights

Solarium, Lounge floor

10:00 a.m.

Gastric Complications Encountered During Therapy of Rheumatic Disease

William H. Kammerer, M.D., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York, N. Y.

Discussor: William J. Snape, M.D., Camden

Study of the relationship of peptic ulcer to corticosteroid therapy in patients with rheumatoid arthritis has led to the conclusion that certain corticosteroids are responsible for gastric ulceration, probably as a result of direct effects on the mucosa.

Peptic ulcer was observed radiographically in 31 per cent of patients with rheumatoid arthritis receiving adrenal steroids, but in only 9 per cent of patients not so treated and in 5 per cent of non-rheumatoid controls. Hydrochloric acid and pepsin secretion were not influenced significantly by the administration of corticosteroids.

Wednesday Morning, April 29, 1959

10:35 a.m.

Joint Changes in Early Malignant and Hematologic Diseases

Irving L. Sperling, M.D., Attending in Arthritis, St. Barnabas Medical Center, Newark

Discussor: William D. Kimler, M.D., Haddon Heights

Joint changes are frequently the first presenting sign of systemic diseases such as malignancies and blood dyscrasias. A fairly representative group of cases have been collected over a period of years, each illustrating joint phenomena for varying periods prior to the clinical manifestations of the malignancy or blood dyscrasia. In addition there are joint changes which occur during the course of the disease and the representative picture will be discussed. Finally, an attempt will be made to indicate the use of this data in earlier diagnosis of these more serious disease states.

11:00 a.m.

Non-Specific Tendinitis and Peritendinitis in Rheumatic Disease

Daniel E. Kavanaugh, M.D., Attending Orthopedic Surgeon, St. Barnabas Medical Center, Newark

Discussor: Alvin Mancusi-Ungaro, M.D., Newark

The onset of non-specific tendon lesions in the neighborhood of a joint can be masked by the pain and disability already existing in the joint affected by rheumatic disease. Prompt recognition and adequate treatment is most essential.

A classification of non-specific non-suppurative tendon lesions will be presented to direct attention to the need for clarity of terminology and for standardization in the use of terms for these lesions.

11:25 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Rheumatism and New Jersey Rheumatism Association

Bakewell Room, 1st floor

Reservations: Georgia E. Allen, M.D.
436 Second Ave., Haddon Heights

Wednesday Afternoon, April 29, 1959

MEDICINE

Henry L. Drezner, M.D., Chairman, Trenton
Thomas M. Kain, Jr., M.D., Secretary, Camden

Viking Room, 13th floor

2:00 p.m.

Paper Electrophoresis—Its Use in the Hospital Clinical Laboratory

David A. Fluck, M.D., Chief of Pathology, The William McKinley Memorial Hospital, Trenton

Paper electrophoresis is a useful diagnostic and prognostic tool in many types of disease including hepatic and renal disorders, agammaglobulinemia, multiple myeloma, lupus erythematosus, certain rheumatoid diseases, hemoglobin abnormalities and diseases of the nervous system. Blood serum, hemoglobin, urine and cerebrospinal fluid can be used for analysis. Pleural and peritoneal fluids offer interesting fields for future experimentation. A project is described in which blood donor serum is used for paper electrophoresis in which follow-up health cards will be sent at intervals to those showing abnormal lipoprotein patterns.

Discussion

2:30 p.m.

Medical Work-Up Prior to Cardiac Surgery

Harry F. Zinsser, M.D., Associate Professor of Medicine, member of the Robinette Foundation for Cardiovascular Research, Hospital of the University of Pennsylvania, Philadelphia, Pa.

This reviews the medical aspects of the care of patients considered for cardiac surgery. It includes pre-operative diagnosis of sufficient accuracy to permit surgery. It also will cover the pre-operative preparation of these patients to permit them to undergo anesthesia and surgery with the lowest possible risk.

Discussion

3:00 p.m.

Fats, Cholesterol, and Coronary Heart Disease

Norman Jolliffe, M.D., Director of Nutrition, Department of Health, New York, N. Y.

The increase of coronary atherosclerosis in the American population has been correlated with the rise in the intake of dietary fat (mostly of the

saturated variety). These fats are derived mainly from animal sources and from hydrogenation of vegetable fats. Saturated fats have been shown to elevate the total serum cholesterol level. Unsaturated fats have a depressant action. A nutritional approach to the control of hypercholesterolemia and atherosclerosis is under study by the Bureau of Nutrition of the City of New York. Essentially, men between the ages of 50 and 59 are given a diet containing 30 per cent fat, high in linoleic acid, and consisting of half predominantly saturated and predominantly half unsaturated fats. The composition of this diet and its practicability for use in a free-living and working population will be presented.

Discussion

3:30 p.m.

A Safer Diuresis with Chlorothiazide by Discontinuous Administration

Milton Shoshkes, M.D., Assistant in Medicine, Newark Beth Israel Hospital, Newark

Co-Author: Mario Tami, M.D., Newark

Chlorothiazide is a potent diuretic, heretofore administered orally in a continuous and daily manner for at least several consecutive days. The authors demonstrate that the optimum dose of this drug is a Gram a day. It is generally as effective a diuretic as mercaptomerin in doses of 2 milliliters intramuscularly. This one Gram oral dose is best given once or twice weekly, to avoid the dangers of hypokalemia, while maintaining an effective diuretic potency.

Discussion

4:00 p.m.

Business Meeting

Nominating Committee

Saturday Evening, April 25, 1959

Bakewell Room, 1st floor

8:30 p.m.

Chairman, Lewis C. Fritts, Immediate Past-President

County	*Delegate*	*Alternate*
Atlantic	David B. Allman	G. Ruffin Stamps
Bergen	G. Barton Barlow	Frederick G. Dilger
Burlington	E. Vernon Davis	R. Winfield Betts
Camden	Frank J. Hughes	James R. Eynon
Cape May		
Cumberland	Carl N. Ware	Mary Bacon
Essex	Marcus H. Greifinger	Kenneth E. Gardner
Gloucester	Louis K. Collins	John J. Laurusonis
Hudson	Aloysius P. Rieman	Joseph P. Donnelly
Hunterdon	Lloyd A. Hamilton	Leonard Rosenfeld
Mercer	Karl T. Franzoni	Floyd D. Gindhart
Middlesex	Charles H. Calvin	Edward F. Klein
Monmouth	Daniel F. Featherston	Louis F. Albright
Morris	Henry O. von Deilen	Francis J. Benz
Ocean	Raymond A. Taylor	William E. Dodd
Passaic	Joseph E. Mott	Joseph R. Jehl
Salem	C. Spencer Davison	Harry W. Fullerton, Jr
Somerset	George E. Barbour	Runkle F. Hegeman
Sussex	Dorsett L. Spurgeon	Robert A. Weinstein
Union	Lorrimer Armstrong	Herschel S. Murphy
Warren	Ralph M. L. Buchanan	John E. Hampton

House of Delegates

President, Kenneth E. Gardner, M.D., Bloomfield
Secretary, Marcus H. Greifinger, M.D., Newark
Parliamentarian, Robert M. Backes, Trenton
Sergeants-at-Arms, Benjamin F. Lee, M.D., Camden
John J. Thompson, M.D., Montclair

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Viking Room, 13th floor

SESSIONS

First Session: 2:30 p.m., Saturday Afternoon, April 25, 1959

1. Call to order
2. Invocation
   Reverend Harvey Bennett, D.D., The First Presbyterian Church, Atlantic City
3. Organization of the House
4. Transactions of 1958 Annual Meeting
5. Introduction of Guests and Delegates from Other States
6. Annual and Supplemental Reports
7. Resolutions
8. New Business
9. Announcements

Second Session: 2:30 p.m., Sunday Afternoon, April 26, 1959

1. Report of Nominating Committee
2. Election
3. Presentation of Presidential Plaques
4. "Our Major League"
   Louis M. Orr, M.D., President-Elect, American Medical Association

Third Session: 9:30 a.m., Monday Morning, April 27, 1959

1. Reports of Reference Committees
2. Unfinished Business
3. Installation of Incoming President
4. Adjournment

Reference Committees

Sunday Morning, April 26, 1959

11:00 a.m.

Reference Committee "A"

Room 1333, 13th floor

Reports of the:

President
Board of Trustees
Secretary
Judicial Council
Executive Officer

Dorsett L. Spurgeon, Chairman	Sussex County
Alan A. J. Stolow	Somerset County
William E. Dodd	Ocean County
Mary Bacon	Cumberland County
John E. Hampton	Warren County

Reference Committee "B"

Room 1344, 13th floor

Reports of the:

Treasurer
Finance and Budget Committee
Publication Committee
Medical Student Loan Fund Committee

Gerard R. Gessner, Chm.	Middlesex County
Joseph E. Mott	Passaic County
Edward G. Bourns	Union County
Sherman Garrison, Jr.	Cumberland County
Morton F. Trippe	Monmouth County

Reference Committee "C"

Mandarin Room, 13th floor

Reports of the:

Medical Service Administration of New Jersey

Medical-Surgical Plan of New Jersey

Joseph M. Gannon, Chm.	Union County
Charles L. Cunniff	Hudson County
Samuel J. Lloyd	Mercer County
William E. Bray	Burlington County
Nicholas E. Marchione	Cumberland County

Reference Committee "D"

Room 1335, 13th floor

Reports of the:

Medical Education Committee
Medical Defense and Insurance Committee

Special Committees on:

Civil Defense-Disaster Control
Physicians Placement Service
Retirement Plan for Physicians
Traffic Safety

Winton H. Johnson, Chm.	Bergen County
William W. Cox	Essex County
Raymond J. Germain	Hunterdon County
Frederick W. Durham	Camden County
A. Guy Campo	Gloucester County

Reference Committee "E"

Room 1337, 13th floor

Reports of the:

Welfare Committee

Subcommittees on:

Legislation
Medical Practice
Public Health
Public Relations

Special Committees on:

Cancer Control
Child Health
Chronically Ill and Aging
Conservation of Hearing and Speech
Conservation of Vision
Industrial Health
Maternal and Infant Welfare
Mental Health
Rehabilitation
Workmen's Compensation

John J. Torppey, Chm.	Essex County
Robert E. Verdon	Bergen County
Joshua N. Zimskind	Mercer County
George G. Green	Monmouth County
Josiah C. McCracken, Jr.	Atlantic County

Reference Committee on Constitution and Bylaws

Bakewell Room, 1st floor

Report of:

Committee on Revision of Constitution and Bylaws

Amendments to the:

Constitution
Bylaws

Lorrimer Armstrong, Chairman	Union County
John J. Bedrick	Hudson County
Raymond J. Gadek	Middlesex County
James R Eynon	Camden County
G. Ruffin Stamps	Atlantic County

Reference Committee on Miscellaneous Business

Rowsley Room, 1st floor

Reports of the:

Annual Meeting Committee

Subcommittees on:

Scientific Exhibit
Scientific Program

Advisory Committee to Woman's Auxiliary

Albert Abraham, Chm.	Morris County
Andrew C. Ruoff, III	Passaic County
Martin E. Tolomeo	Somerset County
Raymond A. Taylor	Ocean County
Herschel Pettit	Cape May County

Reference Committee on Resolutions and Memorials

Room 1332, 13th floor

To consider:

Nominations for Honorary Membership
Nominations for Emeritus Membership
Resolutions
Memorials

John L. Olpp, Chm.	Bergen County
Ernest F. Purcell	Mercer County
E. Vernon Davis	Burlington County
Henry O. von Deilen	Morris County
Louis K. Collins	Gloucester County

Reference Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Robert H. Areson, Chm.	Essex County
Marcus H. Greifinger, Ex-Officio	Secretary
Rudolph C. Schretzmann, Ex-Officio	Treasurer

32nd Annual Meeting
Woman's Auxiliary

CHALFONTE, ATLANTIC CITY

April 25, 26, 27, 28, 29, 1959

MRS. SAMUEL L. KAMAN, Chairman
MRS. ANTHONY G. MERENDINO, Co-Chairman

Daily Schedule

Saturday, April 25, 1959

12:00 noon—Registration Opens
Lounge, Lounge floor, Chalfonte
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

3:30 p.m.—Golden Merit Award Ceremony
Viking Room, 13th floor, Haddon Hall

Sunday, April 26, 1959

10:00 a.m.—Registration—Breakfast and Luncheon Tickets
Lounge, Lounge floor, Chalfonte
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

1:00 p.m.—Art Exhibit—County Press and Publicity Book Exhibit
Lounge, Lounge floor, Chalfonte

1:00-3:00 p.m.—Coffee Service
Hospitality Lounge, Lounge floor, Chalfonte

3:30 p.m.—Presentation of Presidential Plaques and Certificates
"Our Major League"
Louis M. Orr, M.D., President-Elect, American Medical Association
Viking Room, 13th floor, Haddon Hall

6:30 p.m.—Fellowettes' Dinner
Zodiac A, Lounge floor, Chalfonte

Monday, April 27, 1959

9:00 a.m.—Golf Matches
Linwood Country Club, Linwood

9:00—11:00 a.m. Coffee Service
Hospitality Lounge, Lounge floor, Chalfonte

10:00 a.m.—Registration—Breakfast and Luncheon Tickets
Lounge, Lounge floor, Chalfonte
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

10:30 a.m.—Pre-Convention Board Meeting
Roberts Room, Lobby floor, Chalfonte

1:30 p.m.—Tea and Lecture
Contemporary Art
Mrs. Arthur Dintenfass
All physicians' wives are cordially invited.
Music Room, Lounge floor, Chalfonte

3:00 p.m.—General Session of the 193rd Annual Meeting of The Medical Society of New Jersey—The members of the Woman's Auxiliary are invited to attend.
Vernon Room, Lounge floor, Haddon Hall

9:00 p.m.—Cabaret—Music and Dancing
Rutland Room, 1st floor, Haddon Hall

Tuesday, April 28, 1959

9:00 a.m.—Registration—Breakfast and Luncheon Tickets
Lounge, Lounge floor, Chalfonte
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

9:00 a.m.—General Session
Music Room, Lounge floor, Chalfonte

9:00 a.m.-11:00 a.m.—Coffee Service
Hospitality Lounge, Lounge floor, Chalfonte

12:30 p.m.—Luncheon
Carolina Room, Lounge floor, Chalfonte

2:30 p.m.—General Session (reconvenes)
Music Room, Lounge floor, Chalfonte

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge floor, Haddon Hall

Wednesday, April 29, 1959

9:00 a.m.—Inaugural Breakfast
Roberts Room, Lobby floor, Chalfonte

10:00 a.m.—Post-Convention Board Meeting
Roberts Room, Lobby floor, Chalfonte

12:00 noon—President's Luncheon for Incoming County Presidents
Blue Room, Lobby floor, Chalfonte

Golf Matches—Linwood Country Club, Linwood
Chairman, Mrs. Matthew Molitch
Art Exhibit—Lounge, Lounge floor, Chalfonte
Chairman, Mrs. Victor A. Bressler
County Press and Publicity Book Exhibit
Lounge, Lounge floor, Chalfonte
Hospitality Lounge, Lounge floor, Chalfonte

Scientific Exhibits

Lobby Floor

Exhibit Hours : 9:00 a.m. - 5:00 p.m., Monday and Tuesday, April 27 and 28, 1959
9:00 a.m. - 3:00 p.m., Wednesday, April 29, 1959

Booth 1. Cardiac Valvular Dynamics—Julio C. Davila, M.D., Robert G. Trout, M.D., Robert P. Glover, M.D., Philip Custer, M.D., and Joseph Sunner, Presbyterian Hospital, Philadelphia, Pa.

The Presbyterian Pulse Duplicator makes possible the graphic study of the normal and diseased cardiac valves functioning under conditions which duplicate living cardiovascular dynamics. This presentation emphasizes the value of the apparatus in teaching: the normal valvular anatomy and function, the effects of disease upon the structure and mechanics of valvular action, and the surgical technics used on actual pathologic specimens at the undergraduate and graduate levels. In the field of research it is useful for the study of valvular mechanics, the investigation of prob'ems in circulatory dynamics simulated *in vitro*, and in the development of advanced corrective operations applicable to valvular heart disease.

Booth 2. Cardiac Glycosides and Their Therapeutic Application—Arthur C. DeGraff, M.D., Leonard B. Gutner, M.D., Lawrence S. Kryle, M.D., Herbert S. Kupperman, M.D., and Arthur Bernstein, M.D., Department of Therapeutics, New York University College of Medicine, New York, N. Y.

The action of cardiac glycosides in heart failure is explained diagrammatically. The pharmacology of the cardiac glycosides is demonstrated by charts. The characteristics of the cardiac glycosides: the latent period, absorption from the gastrointestinal tract, rate of dissipation, dosage, therapeutic range and toxicity are shown for each glycoside.

Booth 3. Maximal Reconstitution of the Mitral Valve—Charles P. Bailey, M.D., Houck E. Bolton, M.D., Henry T. Nichols, M.D., Dryden P. Morse, M.D., and William Likoff, M.D., Bailey Thoracic Clinic, Philadelphia, Pa.

The surgical correction of mitral stenosis by necstrophingic mobilization is presented. Illustrative material covers the pathology and surgical procedure. This consists of color transparencies, schematic representations and three dimensional visualizations. The results of surgery are presented graphically.

Booth 4. Physiologic Cardiovascular and Pulmonary Surgery—Ralph Lev, M.D., and Lucy Aiello, M. T., Princeton Hospital, Princeton; Hunterdon Medical Center, Flemington; and The Mercer Hospital, Trenton

This is a pictorial display and equipment demonstration of the physiologic principles and practices used for the diagnosis and surgical treatment of various cardiac, vascular and pulmonary lesions in a community hospital. These include pulmonary function studies, angiocardiography, aortography, peripheral angiography, special cardiac catheterization studies such as direct ventricular puncture, oximetry and dye curves. The fundamental principles and application of hypothermia and cardiopulmonary bypass are demonstrated.

Booth 5. This is Arthritis—The Arthritis and Rheumatism Foundation, New Jersey Chapter, Newark

The exhibit will consist of three panels: (1) Educational information directed to the doctors' patients; (2) Description in color and light of normal knee joints afflicted with rheumatoid arthritis —through five separate stages of deterioration on to the final condition of ankylosing; and (3) Professional education literature in poster form.

Booth 6. Surgery for Aortic Stenosis—A Safer Technic—Houck E. Bolton, M.D., Edmund C. Hessert, Jr., M.D., and David L. Andrus, M.D., West Jersey Hospital, Camden; and Hahnemann Hospital, Philadelphia, Pa.

This exhibit presents a method for the surgical correction of aortic valvular stenosis. Previous operative mortality for these patients has been approximately 25 per cent. Using the drug lidocaine during surgery, the operative mortality has been reduced to about 8 per cent. Thus, the operation for relief of aortic stenosis is well within the realm of reasonable operative risk.

Booth 7. Diabetic Clinic—V. A. Regional Office —Otto Brandman, M.D., Agatha Kelley, R.N., and Winifred Sullivan, Veterans Administration Regional Office, Newark

This exhibit highlights the fact that the diabetic patient has to be treated as a whole, with particular attention to certain organs (eyes, kidneys, peripheral-vascular system). Dietary instruction of the patient is an inherent part of the regime, as is personal hygiene. These points are illustrated. A close cooperation with the patient and regular visits to the clinic may decrease and frequently prevent many crippling complications.

Booth 8. Cerumenolysis—James Q. Gant, M.D., and Manning J. Rosniek, M.D., Skin and Allergy Clinics, Veterans Administration Regional Office, and George Washington University, Washington, D. C.; and University of Miami, Coral Gables, Fla.

The clinical problem of excessive cerumen has been related to a variety of pathologic symptoms ranging from deafness and vertigo to exfolliative dermatitis. This exhibit describes the pathogenesis

of ceruminosis, the pharmacology of cerumenolytics and the clinical utility of the procedures suggested to remove cerumen. Particular emphasis is placed upon the pitfalls of these technics and the over-all results which may be expected. Experiences with several hundred patients are reported by means of charts, drawings, photographs, and models.

Booth 9. The Non-Operative Aspects of Pediatric Surgery—Richard C. Reed, M.D., and Celestino Clemente, M.D., Babies' Hospital Unit, United Hospitals of Newark

The truly effective management of any surgical problem in an infant or a small child embraces certain equipment and little "tricks of the trade." It is our purpose to demonstrate several aspects of the pre- and postoperative care of pediatric surgical patients.

Booth 10. Pathology of the G. U. Tract in Natural Color—Martin R. Rush, M.D., and Alfredo D. Zavaleta, M.D., Monmouth Medical Center, Long Branch

The display shows a broad range of lesions of the genito-urinary tract in natural color. Actual demonstrations will be held daily to demonstrate the technic of color restoration. In addition to the specimen presentation, the exhibit will be on the basis of restoring the medical museum to its rightful place in the field of medical education since the technic is reproducible in any size hospital. The cost is lower than the traditional museum jars. Panels or show cases may be constructed locally. Since they are only four inches thick, they will not affect the already overcrowded hospitals.

Booth 11. Elective Rhinoplasty—Irving B. Goldman, M.D., New York, N. Y., and Irvin J. Fine, M.D., Perth Amboy

This exhibit will present the effect on postoperative sequelae (edema, discoloration and pain) of therapy with prednisone following cosmetic surgical procedures. It will include the rationale for this therapy and data illustrating the marked suppression of the inflammatory response consequent to surgical trauma. Kodachrome transparencies of patients will be included.

Booth 12. Is It an Allergy?—James M. Steele, M.D., Guthrie Clinic, Robert Packer Hospital, Sayre, Pa.

The diagnosis of allergy is often confusing, since allergic pathology is reproducible by other mechanisms. However, such definitive diagnosis should precede intensive efforts to identify allergens. A scoring system has been developed which is of assistance in clarifying the presence or absence of the atopic state. This exhibit describes this technic with demonstration of its application.

Booth 13. Peptic Ulcer in the Golden Age—Abraham I. Friedman, M.D., Bergen Pines Hospital, Paramus

One hundred and twenty-five hospitalized patients with peptic ulcer disease over age 60 were studied. Almost half presented a history that began after age 50. Hemorrhage, the most frequent complication, was found in 50 per cent, perforation in 8 per cent. A comparison of the results of medical vs. surgical treatment is presented. The special problems of diagnosis and therapy in the older age groups, particularly when complications occur, are discussed. A more aggressive surgical attitude for the complications of peptic ulcer is recommended.

Booth 14. Clinical and Thoracic Roentgen Features of Sarcoidosis—Samuel Cohen, M.D., Mario J. Albini, M.D., and David Abed, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City

The clinical and x-ray features of sarcoidosis are reviewed and x-ray films of interesting cases are presented. This review is based on 45 cases, in which 20 had histologic confirmation. All of the patients had abnormal chest x-rays, 7 per cent had ocular lesions, 9 per cent bone lesions, and 16 per cent had skin lesions. Forty of the 45 are living; three have been followed less than 6 months. The longest follow-up has been 18 years. Eighteen have been observed 5 to 9 years. The causes of death in the remaining 5 cases were (a) respiratory insufficiency and chronic cor pulmonale (2 cases), disseminated tbc (2 cases), cause unknown (1 case). Nine patients received steroid therapy for varying periods.

Booth 15. Synthetic Oxytocics in Obstetrics—Herschel S. Murphy, M.D., Roselle; Ernest C. Lowenstein, M.D., Rahway; Floyd D. Gindhart, M.D., Trenton; and Archibald K. Maness, M.D., Greensboro, N. C.

This study discusses the chemistry and pharmacodynamics of the recently developed synthetic oxytocics; synthetic oxytocin (Syntocinon®) and methylergonovine maleate (Methergine®). Administration includes the following procedures: (a) Intravenous drip of synthetic oxytocin for induction of labor. (b) Combined use of synthetic oxytocics (synthetic oxytocin, and methylergonovine maleate) parenterally in the third stage of labor. (c) Synthetic oxytocin alone, administered undiluted parenterally in cesareans. Results of various obstetrical procedures are statistically analyzed.

Booth 16. Abdominal Pregnancy—Roentgen Criteria—C. Richard Weinberg, M.D., Semir Abbasoglu, M.D., and Gerard Cicalese, M.D., Harrison S. Martland Medical Center, Newark

The authors have formulated seven roentgen criteria for the x-ray diagnosis of abdominal (extrauterine) pregnancy on routine antero-posterior and lateral films of the abdomen. This exhibit will acquaint the treating physicians with the criteria and demonstrate that the diagnosis can be established on routine films of the abdomen in the last trimester of gestation. Maternal morbidity and fetal mortality can be decreased if x-rays are ordered in cases where the diagnosis of abnormal fetal presentation is clinically suspected. Proved cases demonstrating the criteria are presented.

Booth 17. Care and Comfort of the Postpartum Patient—C. Donald Kuntze, M.D., Hoboken

With line drawings, color transparencies and charts, this exhibit presents a new concept aimed at increasing the comfort and speed of recovery of the postpartum patient. Annoying complications such as hemorrhoids, fissures in ano, constipation and the general discomfort of the patient are minimized or eliminated completely. The use of vaginal rather than rectal examination during labor, permitting the free intake of fluids postpartum and the use of a physiologic approach to defecation in the postpartum period are all aimed at increasing the comfort of the obstetrical patient.

Booth 18. Fallopian Tuboplasty—Critical Evaluation—Mario A. Castallo, M.D., Amos S. Wainer, M.D., and Nicholas A. Policarpo, M.D., Jefferson Medical College, Philadelphia, Pa.

The exhibit shows the technic of fallopian tuboplasty using polyethylene tubing. A critical evaluation of the results shows that polyethylene tubing increases the ratios of patent fallopian tubes and pregnancies. Fallopian tuboplasty is not a panacea for all cases of sterility with tubal occlusion. Careful evaluation of both husband and wife are essential to proper consideration of cases for fallopian tuboplasty.

Booth 19. Progressive Muscular Dystrophy—Ade T. Milhorat, M.D., New York Hospital, New York, N. Y.

The informational value of this exhibit lies in the presentation of a concise and medically accurate outline of the symptoms, progression and common forms of progressive muscular dystrophy. It includes figure drawings indicating progressive weakness and wasting as noted first in proximal muscle groups and later in nearly all striated musculature. Gross changes in advanced cases are illustrated. The center panel carries an automatic projector on which rotating color slides (silent) outline the manifestations. The slides visually supplement the basic information in the first panel and give indication of postural changes which occur during progression. The right panel includes a concise statement on the common forms of dystrophy and their onset, course and duration in persons of varying ages. Differential diagnosis is outlined.

Booth 20. Electromyography—Classical, Present and Future Uses—Earl F. Hoerner, M.D., New Jersey Orthopaedic Hospital, Orange

The exhibit demonstrates the value of electromyography in neuromuscular diagnosis. It displays the technic used in the root impression syndrome. Also pointed up is conduction time of peripheral nerves with diagnostic value of this in the neuritis compression syndrome, myasthenia gravis and other peripheral nerve, or myoneural junction involvement.

Booth 21. The Psychic Factor in Prenatal Symptomatology—Henry A. Belafsky, M.D., Samuel Breslow, M.D., Jack E. Shangold, M.D., and Leonard Hirsch, M.D., Perth Amboy

The importance of the emotional factor in prenatal symptomatology is discussed. Also reviewed are specific symptoms such as nausea, vomiting, headache and insomnia. Use of tranquilizing medication to control the symptoms, and the results of such therapy among more than 800 patients in all trimesters of pregnancy are detailed. A guide to management of the emotional factor is offered.

Booth 22. Fibrositis—Recognition and Treatment—Irvin F. Hermann, M.D., Kenneth M. Kron, M.D., Russell A. DelToro, M.D., and Richard T. Smith, M.D., Benjamin Franklin Clinic, Philadelphia, Pa.

Fibrositis, probably better described as "muscular rheumatism," should no longer be considered a disease of unknown etiology nor as an integral part of other rheumatic conditions. Its incidence is rising because of the unfortunate increase of our sedentary living habits. Traditional therapeutic measures are only partly successful and actually may permit this generally considered benign condition to become a cause of progressive disability and crippling. The prevention of muscular rheumatism is a national problem which must be overcome before it can jeopardize our national security. Rational therapy based upon correcting the cause of the condition instead of symptomatic therapy which temporarily relieves symptoms is eminently successful. The problem, the cause and proper treatment will be discussed.

Booth 23. Chemical Refinement of Bank Blood—Thomas F. Nealon, Jr., M.D., Edward D. McLaughlin, M.D., and John H. Gibbon, Jr., M.D., Department of Surgery, Jefferson Medical College, Philadelphia, Pa.

This exhibit demonstrates a method of correcting altered levels of electrolytes in bank blood by passage of the blood over ion exchange resins.

The most desirable blood for transfusion is fresh blood. However, bank blood has been shown to be a satisfactory substitute in healthy individuals requiring limited amounts of blood. Bank blood undergoes chemical alterations during storage. These include elevated levels of ammonium, potassium, citric acid, lactic acid, pyruvic acid and plasma inorganic phosphate, and a lowered pH and plasma chloride concentration. Such changes make the administration of such blood dangerous in any quantity to individuals with liver and kidney disease, and hazardous to use on anyone in large amounts. Bleeding tendencies, prolonged shock, cardiac arrest and other manifestations of citrate intoxication have been associated with massive transfusion of bank blood during pediatric and cardiac surgery. These are undoubtedly related to lowered pH and altered concentration of electrolytes and metabolites in the stored blood. Methods of decreasing these substances are presented.

Booth 24. Hodgkin's Disease in Childhood—Harold W. Dargeon, M.D., Charlotte Tan, M.D., and Mauricio L. Origenes, M.D., Children's Tumor Registry and Pediatric Service, Memorial Center, New York, N. Y.

Hodgkin's disease occurs rarely in American children. A total of 45 children with Hodgkin's disease seen at Memorial Center in the past 30 years were analyzed. Their clinical courses, therapy, and survival time will be presented.

Booth 25. Vomiting—Causes and Control—Irwin Roseff, M.D., William B. Abrams, M.D., Jerome G. Kaufman, M.D., Lester M. Goldman, M.D., and Arthur Bernstein, M.D., Newark Beth Israel Hospital, Newark

The mechanisms of vomiting, from diverse sources, are described pictorially. Particular attention is given to the neurophysiology of vomiting. The anatomic sites of action of emetic agents are depicted. Current concepts are set forth regarding the actions of various antiemetic drugs.

Booth 26. The Peripheral Vascular Dynamics of Bowel Function—Alfred Halpern, Ph.D., David Selman, M.D., Herbert E. Shaftel, M.D., Paul H. Kuhn, M.D., and Norman Shaftel, M.D., Stuyvesant Polyclinic, New York, N. Y.

The principal source for emboli interfering with the pulmonary circulation is the peripheral venous circulation. However, the mechanism for the introduction of a blood thrombus into the circulation remains to be demonstrated. A study of the effects of the straining patterns of both constipated and normal subjects on the dynamics of venous circulation, segmental and digital blood flow and peripheral vascular resistance, suggests a rationale for this occurrence. This exhibit describes the fluctuation of the peripheral circulation observed during actual and simulated bowel function. The frequently overlooked pitfall of stool straining may have serious consequences for the patient predisposed toward vascular disease.

Booth 27. A Phase of Postoperative Physiology—Timothy A. Lamphier, M.D., Boston, Mass.

This exhibit reviews the physiology of the small and large intestines and a new method of re-establishing postoperative bowel function. With the introduction of new drugs, surgical technics and anesthetics, the problem of postoperative bowel physiology has often been disregarded. The routine in most institutions has been to give a soapsuds enema on the third postoperative day. For too many patients the pain and discomfort of an enema remain in their minds long after other unpleasant symptoms connected with surgery have been forgotten. In addition, the administration of an enema is a time consuming and disagreeable task for nurses and their aides.

Booth 28. Aorto-iliopelvic Lymphadenectomy with Resection for Cancer of the Left Colon and Rectum—5-year Survivals—Harry E. Bacon, M.D., Julius L. Berkley, M.D., Julio R. Pineda, M.D., and Burchard E. Winne, M.D., Temple University Medical Center, Philadelphia, Pa.

Aorto-iliopelvic node dissection with ligation of inferior mesenteric artery at aortic origin in 440 patients is presented. Of 168 cleared specimens by the Spalteholz-Gilchrist technic, the incidence of positive nodes was 63 per cent; 17 per cent were classified as Dukes C_2 located in immediate origin of inferior mesenteric artery. Of the 11 patients with positive inferior mesenteric nodes (aortic origin) removed prior to December 31, 1952, seven presumably died of cancer, one of coronary occlusion, and three are living and well. The survival rate is calculated to have been increased 5 per cent (55 per cent in 1949 to 60 per cent in 1957) for lesions of the descending colon and the rectum.

Booth 29. Hemostasis in Retropubic Prostatectomy—Anthony R. Fernicola, M.D., Columbus Hospital, Newark; and James R. Phillips, Medical Illustrator, Newark

The purpose of the exhibit is to show how hemostasis is achieved in retropubic prostatectomy.

The exhibit will show that the exclusive prevesical manipulation on the bladder surface in the approach to the prostatic capsule provides the ideal method of management of blood vessels which are evaded or handled under vision.

Educational Exhibits

Gallery, Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, April 27 and 28, 1959

9:00 a.m. - 3:00 p.m., Wednesday, April 29, 1959

Booth 1. New Jersey Rehabilitation Commission—Henry A. Brodkin, M.D., Medical Administrative Consultant, Newark

The New Jersey Rehabilitation Commission exhibit concisely outlines, through pictures and posters, the work of the Commission in returning mentally and/or physically disabled workers to the fullest mental, vocational, social and economic usefulness of which they are capable. Vocational rehabilitation is not charity. It is a public service for the disabled of New Jersey comparable to public education, public health and other activities for the welfare of the people.

Booth 2. Chronic Illness Control—Special Committee on Chronically Ill and Aging, The Medical Society of New Jersey; and Division of Chronic Illness Control, New Jersey State Department of Health, Trenton

This exhibit displays statistical information relative to heart disease among physicians and includes reference to etiologic factors such as stress, obesity, diabetes, and hypertension.

Booth 3. Fluoridation—New Jersey State Dental Society, Camden

This exhibit is designed to emphasize the importance of fluoridation as a public health measure in the prevention of dental caries.

Booth 4. Medical Civil Defense—Jack R. Karel, M.D., Medical Coordinator, Union County CD-DC; and Chairman, Civil Defense Committee, Union County Medical Society, Elizabeth

The exhibit will demonstrate the functions of the Health, Medical and Special Weapons Section of the County CD & DC. It will show the relationship of every doctor to Civil Defense and Disaster Control in his community. Because of the pressing importance of radiation defense, an actual model of a family shelter for protection against radioactive fallout will be shown. This shelter is simple, effective and can be constructed in a basement or in the backyard. An emergency medical field box has been devised for easy transportation in a car to a scene of disaster. The medical team could give emergency treatment for all phases of first aid, fractures, burns and shock. Hospital disaster plans of Union County will be shown.

Booth 5. Association of American Physicians and Surgeons, Chicago, Ill.—Joseph A. Lepree, M.D., Elizabeth

The purpose of the exhibit is to familiarize physicians in New Jersey with the programs of the Association.

Booth 6. 300 Most Commonly Prescribed Prescription Products in New Jersey, 1958—R. George Kedersha, Ph.D., and John L. Voigt, Ph.D., Rutgers, The State University, Pharmaceutical Extension Division, New Brunswick

Prescription products that have appeared in a frequency of one or more times per 1000 prescriptions will be on display.

Technical Exhibits

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, April 27 and 28, 1959
9:00 a.m. - 3:00 p.m., Wednesday, April 29, 1959

Abbott Laboratories — Booth 64

Exhibit will feature the Abbott Laboratories Antibiotic Triad—three products which together provide control of all coccal infections: Erythrocin® Stearate, Compocillin®-VK and Spontin®. Also shown will be Abbott's unique new "metered release dose form" products, Tral Gradumets® and Desoxyn Gradumets® plus a selection of other Abbott specialties.

American Ferment Company, Inc. — Booth 20

Featuring the digestant, choleretic laxative action of Caroid® and Bile Salts Tablets as a logical complement in modern methods of therapy. Stop by for a personal supply of Alcaroid Antacid® or Falgos®, the buffered analgesic advertised only to the profession. Also featured: Supligol®, a whole bile acid compound tablet.

Ames Company, Inc. — Booth 30

Featured at the Ames Company exhibit will be the latest developments in new, simplified diagnostic products, which are adaptable to routine examination and patient management. The many advantages of the new diagnostic products are quickly demonstrable, and you are cordially invited to stop at the Ames booth to see them.

Diagnostic products featured at the booth will include Uristix®, Ketostix®, Acetest®, Clinitest® and Phenistix® (new "dip and read" strip test designed for the detection of phenylketonuria).

Audio-Digest Foundation — Booth 12

Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast"—compiled and reviewed by a professional Board of Editors—may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally recognized authorities.

Ayerst Laboratories, Division of American Home Products Corp. — Booth 22

A most cordial invitation is extended to all physicians to visit Ayerst Laboratories at Booth No. 22 where we will be featuring Murel® and Formatrix®. Our representatives will be on hand to discuss with you information on these products as well as any other Ayerst products you might be interested in.

Baby Service, Inc. — Booth 56

Once again Baby Service, New Jersey's largest diaper service, will be on hand to greet the doctors, their wives and guests. The famous Baby Service red rose will be given to each of the ladies and the latest improvements in diaper service shown to the doctors. Come one, come all.

The Baker Laboratories, Inc. — Booth 55

You are invited to visit our booth where Baker's Modified Milk and Varamel®, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss with you the special features of Baker Milk products which promote better tolerance, less colic, better gain and improved tissue turgor for bottle-fed infants.

E. and W. Blanksteen — Booth 2

Information and literature is available at this booth regarding The Medical Society of New Jersey plans of accident and health and life insurance.

The Borden Company — Booth A

Most important new item at the Borden Pharmaceutical Division's booth is Liquid Bremil® which adds all the convenience of a liquid to the significant advantages already established by Bremil® Powdered. Borden's full line of formula products is on display including MullSoy®, the original hypoallergenic formula. Other new additions are Dermabase® and Junitar®, the nonstaining tar bath, and Marcelle® Hypoallergenic Cosmetics, pure beauty aids for delicate skins.

Bristol-Myers Products Division — Booth 46

Bufferin®, the better-tolerated analgesic for long-term, high-dosage salicylate therapy will be featured by Bristol-Myers. Bufferin's® perfectly balanced formula assures maximum absorption without gastric irritation, resulting in good patient cooperation. Relief from arthritic "morning stiffness" is rapid. Bufferin® contains no sodium, caffeine, or other sometimes contra-indicated ingredients.

Burroughs Wellcome & Co. (U.S.A.), Inc. — Booth 54

The extensive research facilities of "B. W. & Co.," both here and in other countries, are directed to the development of improved therapeutic agents and technics.

Through such research "B. W. & Co." has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs.

An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

Cameron Surgical Specialty Company **Booth 61**

The Cameron Exhibit (61) is extremely interesting as usual.

The 1959 models of electro-surgical units in 3 sizes, all new, all different this year, are on display.

The safety model headlites and 6 volt transformers for operating rooms are a "must" for all surgeons.

The Cameron Becker stainless steel rectal sets may be seen along with both distally lighted and double lighted sigmoidoscopes.

Don't miss this exhibit.

Ciba Pharmaceutical Products, Inc. **Booth 33**

Esidrix® is hydrochlorothiazide, an improved analog of chlorothiazide. Milligram-for-milligram, it is the most effective oral diuretic-antihypertensive known. Therapeutically, Esidrix® is 10 to 15 times more potent than chlorothiazide. Weight losses up to 56 pounds have been reported. In many cases Esidrix® caused copious diuresis in patients unresponsive to other oral and/or parenteral diuretics. Side effects are usually mild, infrequent and readily controlled.

The Coca-Cola Company **Booth 45**

Ice-cold Coca-Cola® served through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City, and The Coca-Cola Company.

Dalzo, Inc. **Booth 36**

Desitin Chemical Company **Booth 38**

Desitin® Ointment: For treatment of burns, ulcers, diaper rash, abrasions, etc.

Desitin® Powder: Relieves chafing, sunburn, diaper rash, etc.

Desitin® Suppositories and Rectal Ointment: Relieve pain and itching in uncomplicated hemorrhoids, fissures.

Desitin® Baby Lotion: Protective, antiseptic.

Desitin® Acne Cream: A non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris.

Desitin® Cosmetic & Nursery Soap: Supermild.

Doho Chemical Corporation **Booth 59**

Auralgan®, otitis media and removal of cerumen.

Otosmosan®, fungicidal and bactericidal in the suppurative and aural dermatomycotic ears.

Rhinalgan®, nasal decongestant free from systemic or circulatory effect.

Larylgan®, throat spray and gargle for infections and non-infectious sore throat involvements.

Rectalgan® for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Dermoplast®, aerosol spray for surface pain, burns, and abrasions. Also obstetrical and gynecologic use.

S. F. Durst & Company, Inc. **Booth 65**

S. F. Durst & Co., Inc., will feature Pedamcth®, oral therapy for diaper rash and for the control of odor in incontinence and Senilex,® designed for the relief of mild mental aberrations and abnormal behavior in the senile. Trained representatives will be on hand to discuss these and other outstanding Durst products.

Eaton Laboratories **Booth 49**

Furadantin®, a specific for urinary tract infections, provides rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria and organisms resistant to other agents. In seven years of extensive use in the treatment of genitourinary tract infections, development of bacterial resistance remains negligible with Furadantin®.

Faulhaber & Heard, Inc. **Booth 3**

Information can be obtained on professional liability protection upon inquiry at Booth No. 3, maintained by your Official Broker, Faulhaber & Heard, Inc.

Protection is also available for professional assistants such as registered or graduate nurses, and x-ray or laboratory technicians.

C. B. Fleet, Inc. **Booth 41**

Fleet will feature Clysmathane®, its most recent contribution in the field of medication by rectum—an advanced method of xanthine therapy. Clysmathane® is a stable solution of theophylline monoethanolamine; easily retained; rapid and uniform absorption, prompt and predictable blood levels; with no rectal irritation after prolonged use.

E. Fougera and Company, Inc. **Booth 39**

You are invited to visit the Fougera Exhibit and to discuss our products with medical service representatives. For your convenience, all literature and sample supplies will be sent to your office.

Geigy Pharmaceuticals **Booth 58**

Geigy Pharmaceuticals extends a cordial invitation to members of the Society to visit their exhibit. Reports of the most recent clinical research studies regarding Butazolidin®, Preludin®, Sterosan® with Hydrocortisone and Dulcolax® will be presented by the staff in attendance.

Gerber Products Company **Booth 66**

A complete variety of supplementary infant foods is offered. Included are one-grain cereals, strained and junior all-meat foods, plain vegetables and fruits as well as high protein cereal, high meat dinners and "soups." Simplified reference material facilitates individualized specification. Ask the representative to mail copies to your office.

Health Insurance Council **Booth 17**

The growth of health insurance is illustrated by charts as well as an exhibit of Council publications on all aspects of health insurance. The Health Insurance Council was set up by the insurance business to provide information and technical assistance to physicians and hospitals.

Kessler Associates, Inc. **Booth 47**

Knoll Pharmaceutical Company **Booth 7**

Dilaudid® Cough Syrup is now available "for coughs that must be controlled." This new preparation combines the antitussive Dilaudid® with the expectorant glyceryl guaiacolate.

Vita-Metrazol® Elixir and Tablets are indicated for hastening postoperative recovery and convalescence as well as fatigue and senility.

Information concerning Dilaudid® Cough Syrup, Vita-Metrazol®, as well as Quadrinal® and other Knoll products is available for your review.

Lamond Products, Inc. **Booth 16**

Featuring a new product: Bur-Cort®, Hydrocortisone (free alcohol) ¼%, ½% and 1% in Bur-Zin® for superior topical penetration. Also featuring Dermasorcin® and Dermasul® for acne and seborrhea. Bur-Zin® (Burow's Emulsion), Dermastringe®; a tincture of salicylic acid, resorcin and acetone. Bentical® Shake Lotion; antipruritic, soothing lotion. Sunprotectol®, hypoallergenic sunscreen.

Lederle Laboratories Division, American Cyanamid Company **Booth 48**

You are cordially invited to visit the Lederle Booth where our medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Achromycin® V, Aristocort®, and many other of our dependable quality products.

Eli Lilly and Company **Booth 69**

You are cordially invited to visit the Lilly exhibit located in space No. 69. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

P. Lorillard Company **Booth 67**

P. Lorillard Company invites you to visit the Kent Cigarette Exhibit.

We are presenting the Story of Kent cigarettes with the exclusive, new Micronite filter, which gives you rich taste with less tars and nicotine in the main-stream smoke than any other leading filter brand.

A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the convention.

Maltbie Laboratories Division, Wallace & Tiernan, Inc. **Booth 57**

Maltbie Laboratories features the new dermatologic ointment, Caldecort®, containing calcium undecylenate, hydrocortisone and neomycin for a comprehensive therapy of skin conditions caused by fungi, bacteria or allergy. Also exhibited are: Desenex®, most widely prescribed for athlete's foot; Nesacaine®, a safe, potent and rapid-acting local anesthetic; Bifran® for the management of the over-weight patient; and Cholans® for the treatment of hepatobiliary dysfunction.

The S. E. Massengill Company, Inc. **Booth 19**

Best wishes from Massengill to The Medical Society of New Jersey for a most successful meeting. Should you desire, Massengill service representatives will be on hand at the Massengill booth to discuss with you any Massengill product in which you are interested. The S. E. Massengill Company and its service representatives would like to cooperate, in any way possible, to make your meeting a complete success.

McNeil Laboratories, Inc. **Booth 15**

Members of The Medical Society of New Jersey are cordially invited to visit our Booth No. 15, Mr. A. A. Hower in charge. Products to be featured are: Butibel®, Butiserpine®, Butisol® Sodium, Paraflex®, Parfon®, Syndrox® and Tylenol®.

Mead Johnson & Company **Booth 24**

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products Company **Booth 60**

Medco presents the Medco-Sonlator® and asks "Why the Medco-Sonlator® instead of ultrasound." Let us show you how this unique unit can locate and treat trigger points of pain. Thus resistant conditions can often be relieved by treating the cause, not the symptom. Also on display will be the Medcolators. A full line of accessories will be available.

Medical-Surgical Plan of New Jersey **Booth 1**

The major accomplishments of 1958 and the new schedule of payments for physicians' services will highlight this year's exhibit of New Jersey Blue Shield at Booth No. 1. Now helping more than 1,800,000 individuals pay medical-surgical bills, Blue Shield last year expended an estimated $24,000,000 on about 273,000 cases—both figures representing new records in the Plan's 17-year history.

Noteworthy among the important benefit revisions that went into effect during the year were more than 600 payment increases for surgical procedures, allowances for electro-shock therapy, increased payments for medical care for hospitalized patients, and larger payments for services to the critically ill for certain diagnosed conditions. In addition to extension of eligible services for outpatient care, fees for anesthesia were also raised.

Visitors to the booth will receive an unusual convention souvenir and again, personal candid polaroid snapshots which proved so popular last year will be presented in attractive photo-mounts to physicians and their wives stopping at the exhibit. Blue Shield representatives will be at the booth to answer your questions about service benefits or Plan operations.

The Mennen Company **Booth 5**

The Mennen Company will exhibit Baby Magic®, America's favorite baby lotion; famous Baby Oil

and Baby Powder for anti-diaper rash protection; and, in addition, Mennen Quinsana®, the fast-acting foot powder that kills athlete's foot germs painlessly.

Merck Sharp & Dohme, Division of Merck & Company, Inc. **Booth 35**

A new and very promising adrenocortical steroid is featured at the Merck Sharp & Dohme booth. Decadron® dexamethasone possesses all the basic actions and effects of other gluco-corticoids but in different degree. Its anti-inflammatory activity is more potent on a weight basis than any other known gluco-corticoid. Electrolyte imbalance is not ordinarily a therapeutic problem. Neither abnormal salt and water retention nor potassium excretion are discernible in most patients receiving therapeutic dosages. In other respects, also, Decadron® is generally well tolerated.

Diuril®—a diuretic compound that possesses favorable biologic properties common to both the mercurial preparations and the carbonic anhydrase inhibitors is also of interest. Diuril® acts essentially without toxic effects or other disadvantages. Following a single oral dose, Diuril® produces effects within two hours which last for 6 to 12 hours. It is repeatedly effective when administered continuously once or twice daily for a long period.

Technically trained personnel will be present to discuss these and other subjects of clinical interest.

The Wm. S. Merrell Company **Booth 32**

Tace®, a "treatment of choice" for suppression of lactation will be featured.

You are invited to discuss these and other Merrell research products with our representatives.

Milex of New York **Booth 51**

Cancer Detection developments will be introduced in Booth No. 51. The Milex Folding Pessaries® will be shown, together with the newest instrumentation for vaginal surgery. Tricho-San® for trichomonas, monilia, and mixed bacterial infections will be attractively displayed. The newest Milex product for post-surgical treatment of the cervix uteri will be shown, Amino-Cerv Cervical Gel®. Milex representatives will be on hand to welcome all members and guests.

The C. V. Mosby Company **Booth 52**

New knowledge, new ideas, new research and technic—all are waiting for you in the newest Mosby books for 1958 and 1959. Come in. Look over these books at your leisure and convenience. If you wish his assistance, our experienced representative will be happy to discuss any book with you.

The National Drug Company **Booth 9**

The National Drug Company exhibit highlights Parenzyme Aqueous®, Parenzyme-B® (Buccal) and Parenzyme® Ointment. The efficacy of the anti-inflammatory, anti-edema agents Parenzyme Aqueous® and Parenzyme-B® has been clinically substantiated for the treatment of traumatic wounds, ulceration, phlebitis, ocular inflammation and for loosening of bronchial plugs in severe pulmonary disease. Our representatives anticipate discussing with you the latest advance in enzyme therapy in the form of Parenzyme-B® (Buccal) and Parenzyme® Ointment.

Nordson Pharmaceutical Laboratories, Inc. **Booth 8**

Ergomar®, the new form of specially processed ergotamine tartrate specifically for sublingual administration in the treatment of recurrent and throbbing type vascular and migraine headache. By passing the gastric and hepatic enzymatic barriers, Ergomar® insures more rapid relief and avoids gastric upset. Also featured—Levonor®, non-stimulating appetite suppressant. Levonor's® smooth action permits its use even during the late evening hours without disturbing sleep. Latest reprints are available on Ferronord® Liquid and tablets, a chelate hematinic, providing rapid hemoglobin response without side effects.

Organon, Inc. **Booth 50**

Physicians are cordially invited to visit the Organon booth for information on useful therapeutic specialties. Included among these will be new and improved Cortrophinzinc®, the long-acting aqueous ACTH indicated for the relief of allergic and inflammatory disorders; Stenisone®, Organon's brand of doubly protected prednisone; Wigraine®, the rapid-acting, complete migraine therapy; and Medache®, the unique new analgesic calmative incorporating proved analgesic ingredients with an effective antihistamine calmative and Nugestoral®, the aid for the abortion-prone patient. Organon representatives will gladly discuss the specialties with all interested physicians.

Ortho Pharmaceutical Corporation **Booth 23**

Ortho cordially invites you to visit Booth No. 23 where the well-known line of obstetrical and gynecologic pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Also featured will be Sultrin® Triple Sulfa Vaginal Tablets possessing all the advantages of Triple Sulfa Cream in convenient tablet form, a new additional to the Ortho therapeutic line. Ortho representatives will welcome the opportunity to answer your questions concerning their products.

Parke, Davis & Company **Booth 28**

Medical Service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Pfizer Laboratories **Booth 14**

Visit the Pfizer display which features Cosa-Signemycin®, Cosa-Terramycin® and Cosa-Tetracyn®, Pfizer's glucosamine potentiated antibiotics. The Pfizer representative will be pleased to provide you with information on Diabinese®—the superior normoglycemic agent, Daricon®—a new anticholinergic compound possessing a high order

of therapeutic effectiveness and prolonged duration of action, and Vistaril® which is classified by the Council on Drugs of the American Medical Association as a psychotherapeutic antihistamine.

The Purdue Frederick Company **Booth 29**

The Purdue Frederick Company will present:

Cerumenex®: A cerumenolytic for the easy and quick removal of excessive cerumen. Non-irritating and non-sensitizing. Contains Cerapon, a new surfactant, with propylene glycol as carrier and chlorbutanol as preservative.

Senokot®: Constipation Corrective. Concentrated total senna glycosides which activate Auerbach's plexus, initiate normal neuroperistalsis.

ProBilagol®: Cholescystokinetic containing d-glucitol and hematropine methylbromide. For biliary disease therapy.

Roche Laboratories, Hoffmann-La Roche, Inc. **Booth 40**

Madribon®, a completely new, low-dosage antibacterial distinguished by particular therapeutic effectiveness in upper respiratory infections. Findings in approximately 10,000 clinical subjects demonstrate that low doses of Madribon®, administered at 24-hour intervals, provide good to excellent results in over 90 per cent of the patients. Madribon® is characterized by a high degree of safety, plus a notable absence of skin rashes.

J. B. Roerig and Company **Booth 42**

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

Ross Laboratories **Booth 4**

As adjunct to the physician's oral reassurance of anxious new parents the Ross Developmental series offers visual materials (Individual Case Records, Behavioral Development Folders, Emotional Development Booklets). Current concepts stress the development of the infant as a whole being. Physiologic infant feeding may be discussed with your Similac® representative.

Sandoz Pharmaceuticals **Booth 27**

Mellaril® the first potent tranquilizer with a selective Mellaril® action (i.e.—no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels.

Bellergal® Space Tabs assures around the clock control of functional complaints (example—menopause symptoms) in the periphery where they originate

Cafergot P-B® the most effective oral medication for the relief of migraine headache with G. I. disturbance accompanied by tension.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products

W. B. Saunders Company **Booth 34**

New Saunders titles of special interest to practicing physicians, on display at the State Meeting will include: Cecil & Loeb, *Medicine;* Roberts, *Difficult Diagnosis;* de Takats, *Vascular Surgery;* Lewis, *Dermatology;* Wohl, *Long-Term Illness;* De Palma, *Fractures;* Boies, *Otolaryngology; Current Therapy* 1959; and Duncan, *Metabolism.*

Schering Corporation **Booth 62**

Schering Corporation welcomes the members of The Medical Society of New Jersey. Our representatives cordially invite you to visit the Schering technical exhibit where they will be glad to discuss with you recent therapeutic advances in Schering research. The products featured will include Deronil®, the steroid of choice; Polaramine®, a highly effective antihistamine, and Trilafon®, an unexcelled tranquilizer and anti-emetic available in a wide range of dosage forms for patient and physician convenience.

G. D. Searle & Company **Booth 26**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Dartal®, the new tranquilizing agent which controls activities associated with anxiety states and other neuroses; Enovid®, the new synthetic steroid for treatment of various menstrual disorders; Zanchol®, a new biliary absterger; Nilevar®, the new anabolic agent, and Rolicton®, a new safe, non-mercurial oral diuretic.

Also featured will be Vallestril®, the new synthetic estrogen with extremely low incidence of side reactions; Pro-Banthine® and Pro-Banthine® with Dartal, the standards in anti-cholinergic therapy; and Dramamine® and Dramamine-D®, for the prevention and treatment of motion sickness and other nauseas.

Seven-Up Developers Association of New Jersey **Booth 18**

Smith Kline & French Laboratories **Booth 31**

S.K.F. features (1) Feosol® Spansul® capsules (new) iron in its most effective form—with a single capsule daily—and usually with a total absence of iron's side effects; (2) Temaril® Tablets and Syrup—oral medications for the relief of itching, both chronic and acute; (3) Vi-Sorbin®, the potent modern tonic that contains B_{12}, B_6, iron and folic acid, and the Absorption Enhancement Factor, D-Sorbitol; and (4) Compazine®, the tranquilizer and antiemetic remarkable for its freedom from drowsiness and depressing effect.

South Jersey Surgical Supply Company **Booth 25**

South Jersey Surgical Supply Company is proud to announce that at the 193rd Annual Meeting, we will introduce the all new Burdick EK-111, Electrocardiograph. In the EK-111 you will find the most dramatic advances in electrocardiography in the last decade. At our booth you will also find

the latest medical equipment and diagnostic instruments.

E. R. Squibb & Sons **Booth 21**

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed.

At Booth No. 21, we are pleased to present up-to-date information on these advances for your consideration.

William Allen Steadman & Company **Booth 11**

This Company is the investment adviser and the underwriter for Steadman Investment Fund, Inc.

It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians in order to provide financial and investment assistance from internship through retirement.

All physicians and their wives are invited to avail themselves of this opportunity to learn more about these organizations.

Thermo-Fax Sales, Incorporated **Booth 13**

Thermo-Fax Sales, Inc., subsidiary of Minnesota Mining & Manufacturing Company, will exhibit Thermo-Fax Copying Products. See how this all electric copying machine can make itemized statements right from a ledger card—complete with patient's name and address in place for window envelope mailing. As many as 500 statements can be made in two hours. Also, this Dry Process copier can reproduce diets, laboratory and insurance reports, and other medical forms.

S. J. Tutag & Company **Booth 68**

S. J. Tutag & Company will present Geritag®. Recent publications have attested to the advantage and efficacy of the 20 to 1 ratio of androgen to estrogen in the treatment of the ever present "aging" problem.

Geritag® formula embodies this very relationship plus a vital range of 9 vitamins, 10 minerals, rutin and 3 lipotropic agents.

Also exhibited will be Quadamine® Granucaps: A sustained release capsule for use in obesity containing appetite depressant, sedation, and full vitamin-mineral supplementation.

The Upjohn Company **Booth 63**

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

U. S. Vitamin Corporation **Booth 53**

Exhibit features C.V.P., an exclusive water-soluble citrus bioflavonoid compound with ascorbic acid—for restoring and maintaining capillary integrity. Corrects or minimizes capillary abnormality and bleeding associated with diabetes, hypertension, epistaxis, purpura, gingivitis and certain forms of gastrointestinal, rectal and vaginal bleeding. Effective therapy in habitual and threatened abortion.

Vanguard Pharmaceutical Corporation **Booth 6**

Walker-Gordon Laboratory Company **Booth 44**

You are invited to taste-test Walker-Gordon milks at Booth No. 44. You will find there the Certified Lo-Sodium® Milk, which has been especially processed to reduce its sodium content from around 500 to less than 50 milligrams per quart. Walker-Gordon Acidophilus Milk, Certified Pasteurized Milk and Certified Skimmed Milk will also be available.

The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, New Jersey, is the world's largest farm producing certified milk. It includes over 2,400 acres of farm land and 2,690 cows and growing heifers.

It is the home of the famous Rotolactor, the purpose of which is to make possible the production of the highest quality milk.

Walker-Gordon Certified Milk is distributed in the metropolitan area of New York and Philadelphia and in the State of New Jersey by many leading milk dealers.

Warren-Teed Products Co. **Booth 43**

Westwood Pharmaceuticals, Division of Foster-Milburn Company **Booth 70**

Westwood invites physicians to stop by their booth to discuss their unique dermatological products: Fostex® Cream, Fostex® Cake, Sebulex®, Lowila® Cake, Lowila® Emollient.

These products are particularly suitable for personal use by physicians and their families, who may be plagued with dandruff, acne, dry itchy skin and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories, Inc. **Booth 10**

Orabiotic Chewing Gum Troches—for effective topical treatment of oropharyngeal infections. Each chewing troche combines neomycin and gramicidin for complimentary effect against pathogens common in oropharyngeal infections. The local analgesic action of propesin is free of adverse effects on the sense of taste so common to banzocaine. Especially effective following tonsillectomy.

Winthrop Laboratories **Booth 37**

Trancopal®, a new major chemical contribution to therapeutics, a nonhypnotic, muscle relaxant and tranquilizer which combines high clinical effectiveness with low toxicity ("as safe as aspirin"), 100 milligram Caplets (average dose 1 Caplet t.i.d.).

pHisoHex®, antiseptic detergent for the prevention of staphylococcus aureus cross infections in hospital.

Annual Reports of County Societies • • •

Bergen

George Heller, M.D., President, Englewood

Since we were organized, 105 years ago, our Society has grown steadily although our rate of increase during the past decade has been less than that of Bergen County's population. During the past year our membership passed the 700 mark while the population of our county reached 750,000. In spite of several recent building programs, all our hospitals are overcrowded. Waiting lists create increasingly troublesome problems. Anticipated delays in securing hospital staff appointments deter some recent graduates from establishing practice in our county.

Our Society has endeavored to keep pace with the growth of the number of people it serves by increasing its activities. Three new committees have been activated: "Hospital Liaison," "Poison Control" and "Chronically Ill and Aged." Our Society functions through 10 standing committees with 11 subcommittees and 17 special committees, a total of 38. With 5 exceptions each committee has had at least one meeting this year.

MEMBERS

During the past year, 36 new applications for membership were approved; 27 became regular members, having completed their term of associate membership; 2 changed their status to regular from courtesy, 3 were elected emeritus members and 1 was given leave of absence. Twelve resigned, 3 transferred to other New Jersey societies and 5 were lost by death. Dr. William Carlos Williams, distinguished poet and author, of Rutherford, was made an Honorary Member of our Society.

MEETINGS

Ten Society meetings were held during the past year. Speakers at these meetings and their subjects were:

March 11, 1958—"Social Security for Physicians, Assets and Liabilities"—Panel discussion.

April 8, 1958—"Reconstructive Plastic Surgery"—D. McCullagh Mayer, M.D.

May 13, 1958—"The Control and Prevention of Accidental Chemical Poisons"—Mr. Harry W. Raybin, New York.

September 9, 1958—"The Diagnosis of Cancer in Office Practice"—Dr. Emerson Day, New York.

October 14, 1958—"The Doctor Looks at the Stock Market"—Mr. Dudley E. Jacobus

December 9, 1958—"Medicine—The Public and the Press"—Mr. Earl Ubell, New York.

January 13, 1959—"Practical Physiology of Deep Sea Diving"—Commander George Bond, USN.

February 10, 1959—"Insurance Problems of Physicians"—Mr. Edmond J. Nouri, N. E. Mutual Life Insurance Co.

March 10, 1959—"A Medical Examiner's Office—Theory and Practice"—Dr. David Spain, New York.

Two public forums were held last spring: March 28, 1958—"The Conquest of Heart Disease"—Moderator, Dr. LeRoy W. Black; panelists, Drs. John T. E. Flynn, Robert E. Kahn and Stewart Alexander: April 16, 1958—"The Conquest of Cancer"—Moderator, Dr. William T. Knight; panelists, Drs. Samuel H. Lipsett, Eric J. Ryan and William J. Roe.

The forums were co-sponsored by the *Herald News* of Passaic, N. J.; each drew about 450 residents.

A forum on diabetes is scheduled for March 17, with a guest speaker and a panel of five members.

The Graduate Education Committee has arranged an 8-lecture seminar on Cancer.

Our Society has been pleased with the results of the first full year of its Emergency Medical Service. 530 county residents called the Service and 99 per cent were satisfactorily cared for.

Poison Control Centers have been set up in 3 hospitals.

During the year a poll to determine the wishes of our members concerning inclusion under the Old Age and Survivors Insurance Act (so-called Social Security) showed that inclusion was desired by a two-to-one majority of those not already covered.

The Speakers' Bureau filled 47 engagements; 16 of which were on cancer.

The Woman's Auxiliary to our Society continues to be active and has raised funds in

support of its nurses' scholarship program. Our own medical scholarship fund, for which all of the money was contributed by the Auxiliary during the past four years, is now organized and ready to consider initial applications.

The Mental Health Committee is organizing a low cost psychiatric clinic—a facility sorely needed.

The committee on a new building was again frustrated by our Society's failure to receive a zoning variance. It is continuing to search for a suitable permanent home.

During the year the Judicial Committee met 6 times and considered 15 complaints.

Through the medium of our monthly *Bulletin*, I have used the "President's Page" to express opinions on controversial subjects. This was done in an endeavor to shake off a certain degree of mental lethargy that too often has permeated groups similar to our own. It is my immodest belief that, in this respect, I have met with some success. Only time can tell whether these few seeds of independent thinking will flourish in years to come.

PROBLEMS

Our Society's major problem, unchanged from the last several years, is how to attract more than 15 per cent of its members to attend regular monthly meetings.

Efforts have been made and will be continued to present speakers on general subjects both medical and non-medical.

Camden

Elic A. Denbo, M.D., President, Camden

Monthly general meetings were discontinued in 1958. Instead, meetings were held in October, January and March, with the Annual Meeting scheduled for May. Outstanding speakers were secured and the attendance was good. This was especially true of the March 1959 meeting which was a dinner meeting held in a local restaurant. The Executive Committee continues to meet monthly.

Under the auspices of our Emergency Coverage Committee another municipal Emergency Service was established and functions well.

Revisions and amendments to our Constitution and By-laws, among other matters, provided a reduction in dues and a larger Executive Committee to represent all sections of the County as well as all phases of medicine.

Other activities include a polling of the membership with regard to Social Security. Returns are not yet completed; approval of the Mental Health Association's pilot program in distributing medications, and a contribution to the Student Loan Fund of The Medical Society of New Jersey.

Cumberland

M. David Baxter, M.D., President, Vineland

During the past year the Cumberland County Medical Society donated a sum of $1460 to the Albert Barker Kump Memorial Grant of the Medical Student Loan Fund. This Grant we feel represents a worthy memorial to our beloved colleague, who was President of The Medical Society of New Jersey at the time of his untimely death on April 18, 1958.

On October 14, 1958, the Society awarded to Dr. Carl Nash Ware a silver tray in recognition of services rendered to organized medicine and to his colleagues in Cumberland County and also at state level.

The Society suffered a great loss when three of its honored and beloved members passed away during the year. These were Horace B.

Loder, M.D., Charles M. Gray, M.D., and John Hays Winslow, M.D.

During the Glaucoma Detection Week Drive, 197 patients were examined in Cumberland County, 119 of whom had sub-normal vision and 33 of whom had other eye pathology.

The Diabetes Detection Drive, headed by Dr. Milton Fineman, was considered to be highly successful. This year for the first time, the drive included on-the-spot testing by use of Clinitest Tablets of many of the school children of Vineland, Millville and Bridgeton. The same sort of program was set up for some of the large industries in our county and testing stations were set up in the High Schools for the townspeople of Millville, Bridgeton and Vineland. All of these tests were conducted by volunteer workers. A total of 2811 examinations were made, of which 39 tests were positive. Dr. Leonard Scott alone tested 100 of his patients and found five positive reactions.

Bringing honor to Cumberland County again was Dr. Sherman Garrison, Jr., M.D., who was elected President of the New Jersey Chapter of the American College of Surgeons. During the February 10 meeting of the Cumberland County Society, the Society voted unanimously to nominate Dr. Garrison for Second Vice-President of The Medical Society of New Jersey at its 193rd annual meeting in Atlantic City.

Essex

Edwin H. Albano, M.D., President, East Orange

During my administration, I have attempted to focus attention on economics to assist us in keeping abreast of the many changes in the financing of medical care. The speakers at our regular meetings were selected to handle various aspects of the economics underlying modern medicine.

Last October we had a highly successful dinner meeting with our Woman's Auxiliary at which Mr. A. P. Alfino of the U. S. Chamber of Commerce spoke on the impact of unions on health plans. He spoke to an audience of approximately three hundred. We had excellent newspaper coverage. At our January meeting we invited Mr. Adolph Held, Director, Welfare and Health Benefits Department of the International Ladies' Garment Workers' Union to discuss labor's impact on medicine.

Our March meeting covered estate planning. Our speakers, Samuel S. Saiber, Esq., Norman E. Schlesinger, Esq., and Mrs. Roland H. Hill, Jr., are authorities in their respective fields. A meeting on medical-surgical coverage was held in April 1959.

DIABETES DETECTION DRIVE

Over two thousand finger-prick blood tests were administered to Essex County residents at our two diabetes testing stations. One hundred and nine were found to be positive. This public testing program was exceedingly successful due to the wonderful community cooperation shown by such groups as the Newark and East Orange Departments of Health, and the State Department of Health. Dr. Louis Grunt, our chairman, had set up the testing stations at the Hospital Service Plan of New Jersey and the East Orange General Hospital.

GOOD P. R.

Our Public Relations Committee, under the chairmanship of Dr. William Greifinger, produced some very fine results. The press gave fine coverage of our meetings and activities. The December 29, 1958, *AMA News* carried a long article about our Society as a community leader. Another article that received nationwide distribution appeared in *Medical News*, and spoke of our founding and sponsoring the Essex County Service for the Chronically Ill. Dr. Frank M. Galioto was interviewed, as Chairman of our Anesthesia Committee, by John Wingate over WOR Radio. He answered questions that the public would like answered about modern anesthesia practices.

HEALTH FAIR

Our Society and our Woman's Auxiliary are co-sponsoring a Health Fair with the Essex County Pharmaceutical Association and

the Junior Chamber of Commerce of the Oranges and Maplewood. It will be held at Seton Hall College in South Orange, on May 7, 8, and 9, 1959. Dr. Carye-Belle Henle is working on an exhibit which will stress Essex County's alertness to modern medical technics and the latest scientific medical equipment.

Dr. S. William Kalb, Chairman of our Speakers' Bureau, reported that he has sent over 300 speakers to the public since last May 1958. I commend Dr. Kalb on the wonderful job that he is doing for our Society and the public relations of the medical profession in Essex County.

We are very proud of all that one of our Past Presidents, Dr. Frank S. Forte, contributed to the field of graduate medical education throughout the state.

Our Woman's Auxiliary has cooperated with us splendidly, and presented some very fine programs of their own. Their President, Mrs. George C. Parell is currently hard at work with preparations for the coming Essex County Health Fair.

Our *Bulletin* is better than ever. Dr. Frank Rosen has added many pictures and special articles this year. He has cooperated in a series of articles with pharmacists and social agencies.

SOCIAL SECURITY POLL

On January 28, 1959, we mailed a questionnaire to our 1630 members, asking them whether they were in favor of compulsory inclusion of physicians under Social Security. The response was amazing: 1267 questionnaires were returned. Of these returns, 865 favored such inclusion and 392 opposed it. Since the majority of our members favor it, I hope something will shortly be done, so that the many physicians who want Social Security coverage will have it made available to them.

During the past three years a great deal of effort was made by Dr. W. W. Cox of our County Society Insurance Committee to get term life insurance for our members at group rates. In deference to the medical societies of smaller counties who could not get a county insurance plan on their own, we pursued this no farther when we heard that the State Society was interested in a plan. We were pleased to hear that this life insurance plan was recently adopted by the State Society.

Our Society donated $2,500 to the Essex County Blood Bank to help equip their proposed new building, and $500 to the Albert B. Kump Student Loan Grant fund.

Our Executive Secretary, Mr. Arthur Ellenberger, has been extremely helpful in implementing our programs, and securing good public relations for our Society.

Mercer

SAMUEL J. LLOYD, M.D., President, Trenton

A number of noteworthy accomplishments were inaugurated and/or achieved by the Mercer County Component Medical Society during the 1958-1959 administration.

The Society was incorporated under the laws of New Jersey on January 5, 1959.

Insurance, covering libel, slander, privacy, piracy, plagiarism and copyright was purchased for the protection of the Society's President, Vice-President, Secretary-Reporter, Treasurer, Members of the Judicial Committee and Council, the Chairman of the Public Relations Committee, and the *Bulletin* of the Mercer County Component Medical Society.

A full-time Administrative Assistant was engaged.

An eligibility questionnaire was developed, and is being used. This form is sent to the New Jersey State Board of Medical Examiners whenever a physician applies for membership in our organization, and includes certain questions which are helpful to our Credentials Committee in determining the eligibility of candidates.

A news release was published in the local newspapers, relative to the continued presence of infantile paralysis in the Mercer County area. This release deplored the present indifference of the public, and urged the eradication of infantile paralysis, which will require the full cooperation of every family in the community. The statement continued, "Every person under 40 years of age should be immunized. Immunization can be done in the office of every family physician. The physicians have pledged to use the tax provided

'shots' for those unable to pay full price, so that fees may be adjusted. For those unable to pay any private fee at all, the Baby Keep Well Stations (up to 6 years of age) and the hospital out-patient clinics are available. One 'shot' now will give some protection in a few weeks and will begin the three 'shot' program which is necessary for full protection against polio in 1959." The release was issued September 23, 1958.

The Mercer County Component Medical Society endorsed the State Society's recommendation that anti-poliomyelitis immunization be made a prerequisite to entrance into the beginning grade of each school system. This recommendation was forwarded to the Boards of Education of Mercer County's public, parochial, and private schools. On March 5, 1959, the Trenton Board of Education acted favorably upon this recommendation.

The Society went on record in favor of a Community Blood Bank in Mercer County, in principle, and approved the sponsorship of a survey relative to the practicability of such in this community.

A poll of the membership was conducted to determine its attitude toward compulsory inclusion of physicians in OASI (Old Age and Survivors Insurance). The response indicated an overwhelming majority *in favor* of such inclusion. A resolution was adopted by the Society on January 14, 1959, with the request that the House of Delegates of The Medical Society of New Jersey place it on the agenda for the 1959 Annual Meeting.

Our organization participated in a chest x-ray survey which covered 10 school districts, selected because of the preponderance of known tuberculosis in these areas. Results of the survey will be of assistance in completing the study of contacts of Mantoux positive children, many of whom have not presented themselves for x-ray.

Letters were sent to all county component societies throughout the State, relative to a resolution adopted by the Mercer County Component Medical Society, urging a retirement contribution plan for New Jersey physicians.

The Mercer County Component Medical Society participated in Diabetes Detection Week (November 16 to 22, 1958) which included newspaper and radio coverage; poster displays and distribution of leaflets *via* Mercer County drug stores, with the cooperation of the Society of Mercer County Pharmacists; displays of diabetes posters and distribution of leaflets through large food markets in Mercer County; distributed Dreypaks, on request, at all boards of health in Mercer County (Trenton and surrounding townships); testing of urine samples in the homes by visiting nurses on their rounds, with the cooperation of the Trenton Visiting Nurse Association; blood tests were offered to all Trenton area state employees during Diabetes Detection Week (nearly a thousand tests were made)—with participants being notified of the results (doctors were told of positive reactors with the cooperation of the Diabetes Control Program, New Jersey State Department of Health).

Our Diabetic Detection and Education Committee instituted a weekly diet counseling course for diabetic patients. The committee canvassed all members of the Society for referrals. This committee, in addition, is developing plans for extension of diabetes case-finding, with the assistance of the Mercer County Visiting Nurses and Public Health Nurses of the Health Departments. The limited project conducted during Diabetes Detection Week by the Trenton Visiting Nurse Association was considered a success.

The Society adopted an Inter-Professional Code for Physicians and Attorneys, prepared by the American Medical Association and the American Bar Association Liaison Committee.

Consideration is being given a proposed revision of our requirements for associate membership, which will make it necessary for associate members to be engaged in the practice of medicine in Mercer County or its environs during the period of associateship (residency training period may not be applied toward this year); make themselves available as members of the emergency medical panel; make application for active membership at the end of one year of associateship; and attend a minimum of three (3) business or scientific meetings during their year of associateship to qualify for election to active membership.

Consideration will be given to a plan, the general principle of which provides that industrial employees be afforded an opportunity, through payroll deductions, of pre-paying Blue Shield-Blue Cross premiums to effect lifetime coverage at the time of retirement.

Mercer Society was represented at a meeting with Parent Teacher Associations, citizens' health committees, and teacher organizations, to rekindle interest in fluoridation. Further developments are expected as the result of an educational program, which is to be directed toward total dental hygiene health, and particularly toward optimum nutrition, rather than directed exclusively to the controversy of fluoridation of water supplies.

The Mercer County Component Medical Society unanimously endorsed the candidacy of Dr. R. John Cottone for Second Vice-Presi-

dent of The Medical Society of New Jersey, in April, 1959.

The Woman's Auxiliary has been very active under the leadership of Mrs. John F. Johnson. Mrs. Johnson arranged a series of highly interesting programs which enlightened, as well as entertained, the membership.

The Woman's Auxiliary continues to staff the refreshment table which follows each of the County Society meetings, and which has proved a real help in increasing the attendance of the membership.

A most successful "Sweetheart Ball," arranged by the Woman's Auxiliary, was well attended by Society members and guests. The income from this activity is dedicated to the Woman's Auxiliary Nurse Scholarship Fund.

The Woman's Auxiliary continues to be a very important part of the activities of the Mercer County Component Medical Society.

Members of the Society of Mercer County Pharmacists were the guests of the Mercer County Component Medical Society at our picnic held June 12, 1958, at the Trenton Country Club.

Our Judicial Committee, under the chairmanship of Dr. John F. Johnson, has conducted the investigation and adjustment of complaints in a most commendable manner.

Our Annual Banquet, held Wednesday evening, December 10, 1958, at the Trenton Country Club, was attended by 205 regular members, 6 associates, and 12 guests. The speaker of the evening was Jacques M. May, M.D., Director of Medical Geography, American Geographical Society, whose subject was "The Geography of Human Disease."

A past-President's plaque was presented to Dr. James A. Fessler, Sr., in recognition of services rendered the Society during his administration (1957-1958).

Golden Merit Awards will be presented to Drs. Nathaniel H. Koplin and L. Samuel Sica at the State Society's Annual Meeting. Both of these physicians have completed fifty years as doctors of medicine.

Our Program Committee (Dr. Kurt Zeltmacher, Chairman; Drs. Raymond E. Miller; Jonathan A. Hammond; George I. Horhovitz; and Thomas S. Harvey) arranged the following scientific sessions:

1. "The Doctor Defendant," a film which dealt with medical professional liability and depicted four representative situations confronting the average physician. At the conclusion of the showing of the film, the Honorable Richard J. Hughes made an interesting commentary on its legal implications, and very graciously answered questions from the floor.
2. "Hiatus Hernia, Peptic Esophagitis, and the Ulcer Diathesis" by Dr. Herbert R. Hawthorne, Professor of Surgery, University of Pennsylvania.
3. "Staphylococcic Infection in the Hospital" by Dr. Howard Steel, Associate Professor of Orthopedic Surgery, Temple University.

On February 11, 1959, the following members were elected to offices for the year 1959-1960:

President—Dr. John A. Kinczel
Vice-President—Dr. Peter J. Warter
Secretary-Reporter—Dr. Ralph N. Cagan
Treasurer—Dr. Joseph R. Burns

Monmouth

David W. McCreight, M.D., President, Marlboro

The growth of our county's population was reflected during the year by a continuing increase in our membership, now numbering 333 in all classifications. Regular meetings of our Society were conducted each month with the exception of July, August and December. Three were business meetings and the other six a combination of scientific presentations and business meetings. The scientific sessions were varied, interesting and well presented.

An efficient and successful organization is a direct reflection of the interest and efforts of its committees of that organization. Our committees functioned in a commendable manner. While space does not allow a detailed account of specific activities, worthy of special mention are the following: Judicial Committee, Program, Public Relations, Speakers' Bureau and Inter-professional Relations. The Public Health Subcommittees, such as Cancer Control, Cardiovascular Disease, Diseases of the Chest and Mental Health, fulfilled their functions and either took active parts in the programs of the various lay health organizations or maintained effective liaison with the respective agencies. Other

committees when called upon have always responded and completed their assigned tasks.

One of our members serves in an advisory capacity to the newly-established Monmouth County Homemakers Service and two others represent the Society on the Welfare Council of Monmouth County. Another of our members has been appointed to maintain liaison with a group of agencies to consider the advisability of a project to survey the continuity of nursing service in our county.

Highlights of the social activities the past year were the annual winter and summer dinner-dances sponsored by the Society and the Woman's Auxiliary. Other social affairs included the annual outing and the annual dinner meeting with the Monmouth County Dental Society and the Monmouth-Ocean County Pharmaceutical Society.

Our Woman's Auxiliary again exhibited its usual willingness to assist the Society in addition to conducting their own programs and projects.

The Executive Committee at monthly meetings administered in large part the business and affairs of the Society. Their regular attendance at meetings and their interest and enthusiasm has made easy of solution the various problems presented during the year.

This opportunity is taken to record my appreciation of the cooperation extended to me by the Officers, Executive Committee, other committees and the membership in general.

Morris

Albert Abraham, M.D., President, Morristown

The Morris County Medical Society opened its program year in June, 1958, with an annual dinner at which guests from the state and several other county medical societies were present. A golf tournament highlighted the day. The Executive Committee has met regularly each month and five scientific sessions were arranged for the members. A joint meeting with the Bar Association of Morris County took place in January, 1959; a large delegation is planned for the annual convention of The Medical Society of New Jersey in April, 1959.

The membership of the Morris County Medical Society of New Jersey increases in number each year as does the surrounding population of the county. The medical society has engaged in many activities during the past year, some of them are listed below. A conference with the Morris County Bar Association, and discussion of the national interprofessional code sponsored by the American Bar Association and the American Medical Association was one activity. The medical society has engaged in considering a county medical society sponsored telephone exchange for the members. A special committee is studythe problem of tetanus toxoid immunization and the possibility of the county society staging a county-wide campaign for mass public inoculation with tetanus toxoid. The county medical society has cooperated with The Medical Society of New Jersey and with the various committees of the state society.

We look forward with pleasure to the inauguration of own own past president, Dr. F. Clyde Bowers, as President of The Medical Society of New Jersey and hope to have a large delegation of members and wives present at that time.

The year will close with our annual June Dinner, Election, and Golf Tournament.

Passaic

THEODORE K. GRAHAM, M.D., President, Paterson

Our Passaic County Medical Society has continued to serve an increased membership and a more health-minded community. Our dues were not increased during the year. We now have 588 members. Blue Cross coverage through the society is 376 members. Calls came in for about 50 speakers; our committees have been ready for service, and functioned upon call. The story of each month has been recorded and sent to all members through our *Bulletin*, a publication of over 40 pages. Through this medium, which has been sparked by Mr. Randall Norris, our Public Relations Counsel, much pertinent information has been available to all our members. We feel that this sort of news keeps our doctors informed about our activities and is a valuable public relations contribution.

As a change from the strictly scientific programs previously presented at the regular meetings which occur during the year, one evening was devoted to an explanation of "Trusts," by one speaker, and of "Investments," by another speaker, both of whom appeared through the courtesy of the Forward Paterson Movement. Recognition of the existence of this civic project seems worthy of mention. This non-medical subject was so well received that we are planning more programs of this type during the coming year.

The Medical Society also acted as an intermediary at a joint meeting of representatives of the six county hospitals and the three newspapers of Passaic County. A very frank discussion of Press-Hospital relations took place and as a result each hospital and each newspaper made a written agreement as to a procedure to facilitate the reporting of news of accident cases and hospitalized patients.

We are in the unique position of owning our own Headquarters. This building has become more and more of a health information center to which the public is turning for facts on medical matters. To improve the servicing of these requests, an up-to-date file of the Society members is being prepared. Each physician has been given a card to be filled out with his specialty, special qualifications, hospital affiliations, *et cetera*. The Society Office has been reorganized and is now headed by Mrs. Kay Cingale, Executive Secretary, and her assistant, Mrs. Catherine Quinn.

The Society Building has been host to a large number of welfare organizations which have used this place for their meetings or have been invited guests to various programs, to mention a few, The Licensed Practical Nurse Association of New Jersey, Division No. 5, Laryngectomee Meetings, Cancer Society Executive Committee Meetings, County Blood Bank Meetings and Mental Hygiene Meetings.

The roster of physicians willing to accept emergency calls has been enlarged and the system of a single answering service to take emergency calls is under consideration.

The planning of a crash program to stimulate poliomyelitis vaccination has been undertaken in conjunction with the Passaic Chapter of the National Foundation.

A postcard has been sent to all members requesting a reply to the question about each member's stand on Social Security. To date returns have been four to one in favor of doctor participation.

A pleasant and social relationship exists between the Society and our Auxiliary. These members have been of great assistance in augmenting the work of the Society by sponsoring the Homemaker Service, Inc. Arrangement of the collation and the answering of calls during meetings is in charge of the Auxiliary. Cooperation is always given to any project such as follow-up of members on the Keogh-Simpson bill, *et cetera*. Encouragement of good relations is also achieved through the annual dinner dance which was a particularly pleasant event this year—our doctors contributing their talent to an entertaining skit.

The active and faithful work of the members of the Welfare Council, the standing and special committees, made for a businesslike administration of all Society affairs. I have had special cooperation from the Board of Censors, the Judicial Committee and the Program Committee, to mention a few, and from the officers who have taken responsibility for many important assignments.

Salem

Charles E. Gilpatrick, M.D., President, Carneys Point

At its final business meeting of the season, the Salem County Medical Society voted to seek to educate the public to the dangers of indiscriminate use of antibiotic drugs and to encourage the public to become actively immunized against tetanus by inoculations of toxoid. The Society also endorsed the action of the medical staff of the Salem County Memorial Hospital in recommending that both inside the hospital and in office practice, the drugs chloramphenicol and Novobiocin be used only in infections with organisms proved to be resistant to all other antibiotics in common use.

The Society has cooperated with the county school system in setting up a training school for practical nurses, now in successful operation. We are participating in the Adult Education Advisory Council for the establishment of other extension courses. Programs during the year have included medical problems of the aging, malignant lymphomas, estate and retirement planning, the stock market, bone marrow transplants in radiation injuries, and treatment of hypertension. The Society recommended the administration of a fourth dose of the Salk poliomyelitis vaccine, to be given one year after the third dose. Of 44 members who expressed an opinion on the inclusion of physicians under Social Security, 61 per cent were in favor, 39 per cent opposed.

Union

Graham C. Newbury, M.D., President, Summit

At the present time we have 531 active members, 38 associate members, 7 members taking residencies, 3 retired members and 13 emeritus members: total—589. We had 7 members who transferred to other county societies, 1 resigned and 5 of our members died during the year. Dr. George A. Seymour, President of the Society, 1942-1943, who died on December 1, 1958, held office during a most difficult year as a third of our membership went into the armed forces and the largest number entered service in August 1942. He did much to help organize the Society's wartime program and his advice was greatly appreciated by those who worked with him. Dr. Seymour will be greatly missed.

This year the Union County Medical Society holds its 90th annual meeting and Dr. John L. Meeker celebrated his 90th birthday in Summit where he is still active. Dr. Arthur E. Tator is celebrating his 50th year of practice.

The Blood Bank Committee has held several important meetings with representatives of Red Cross, labor and hospital administrators. The Society approved the recommendations of the committee and one recommendation has been made operative. The Overlook Hospital Blood Bank has assumed the role of clearing house for information regarding daily inventories of the banks in the county. The inventories are reported daily to the Blood Bank and when the information is tabulated, the composite of the inventories is relayed to the cooperating hospitals. This is of great assistance in locating urgently needed types of blood.

The past year was one of increased progress in civil defense activities in the county. More and more doctors are becoming civil defense minded and taking a greater interest in municipal CD activities. Every hospital in Union County has an effective Hospital Disaster Plan in being and has been tested with the aid of the Boy Scouts.

All doctors and dentists have received up-to-date literature to acquaint them with the "Medical Aspects of Nuclear Radiation." Because Radiation Defense is now one of the most important phases of the medical section of civil defense, over 600 individuals have completed courses in Radef monitoring and also courses for use in municipal control centers.

All hospitals in Union County have organ-

ized Radef teams and have received Radef detection instruments from the Union County CD and DC.

Five 200-bed Civil Defense Emergency Hospitals are being established throughout the county. Medical teams for these hospitals are being organized immediately and are to be assisted by dental teams assigned by the Union County Dental Society. Nursing and administrative personnel for these hospitals are being supplied by the Union County Medical Assistants Society.

An exhibit on Medical Civil Defense, directed by Dr. Jack R. Karel, Chairman, Civil Defense Committee of the Society and Medical Coordinator, Union County Civil Defense and Disaster Control, will be shown at the annual meeting of The Medical Society of New Jersey, April 25-29, at Atlantic City.

The 38 associate members attended the indoctrination meetings which again were held this past year at the home of a member of the Woman's Auxiliary. They proved most informative and the social hour that followed gave the members from all parts of the county an opportunity to get to know each other. We have found that the associate members not only attend the required number of meetings but have continued attendance as regular members and they are very interested in the affairs of their Society. The program is now in its fifth year and has proved one of the most beneficial projects established by our organization. The Emergency Medical Service is still a great part of the indoctrination program and most important in fulfilling our obligations to our patients and patients-to-be.

The annual outing last fall, at the Plainfield Country Club, was one of the most successful ever held and had the largest attendance in many years. Guests were Mr. Lundquist, White Laboratories, our hospital administrators and interns. Many members played golf while others went fishing, and in the evening a delightful buffet supper was served.

The Society endorsed the recommendation made by the Public Health Committee that it become mandatory that all new students in the schools should have had their Salk vaccine immunization or should be in the process of receiving the course of immunization before admission. The Boards of Education throughout the county were informed and we have been very pleased by the replies from several Boards of Education that Salk vaccine immunization is now mandatory and others are considering the plan favorably.

The Program Committee presented outstanding speakers at all of the meetings and we had the privilege of having Dr. Kenneth E. Gardner, President of The Medical Society of New Jersey and Mr. Richard I. Nevin, as our guests last fall. The Program and Public Relations Committees provided a most informative panel presentation "What Is News." The panel consisted of the president of the New Jersey Press Association, Mr. Gregory Hewlett; Mr. Charles M. Ray, editor and publisher of the Cranford Citizen and Chronicle; Mr. Stewart Smith, city editor of the Plainfield Courier-News; Mr. Carl Hulett, editor of the Summit Herald, and representatives of the Elizabeth Daily Journal, the Newark News and the Newark Star-Ledger. The attendance at our meetings has been growing steadily and at our annual meeting we had 124 members present. This is almost the capacity of White Laboratories where we have had the privilege of holding our meetings for the past several years.

The Public Relations Committee has, as always, been one of our most active groups and the Press Dinner was the most successful one ever held by the Committee. There were nine newspapers represented this year at our fifth annual press dinner—twice the number ever present before. Many subjects of mutual interest were discussed and clarified. Members of the committee called for some of the guests and we felt that this personal contact brought a number that would not have attended otherwise. This custom will continue.

The administrative details of the Executive Office were carried out with the ever increasing demands for information and assistance by new residents, patients, organizations and members of the Society. The population is still increasing rapidly as well as the many new physicians locating in our area. We knew it would be difficult to replace Mrs. Brown and it was not until December that we were able to do so. Mrs. Carol Fitzgerald has proved a most welcome and efficient addition to our staff.

The list of all of the members who worked so diligently, who gave up their evenings and Sundays to attend county meetings and State Society meetings is indeed a long one and we are most grateful to them. The cooperation of our members has made this year a most satisfying one for projects completed and for those planned for the coming year. My appreciation also to Miss Rogers and Mrs. Fitzgerald for their assistance this past year.

Warren

John E. Hampton, M.D., President, Washington

The Warren County Medical Society, a small group of very busy physicians, is proud of the record of its members during the past years.

Individual members of the group have spent many Sundays at Trenton participating in the work of various committees of the state society. We are proud to have as our secretary the Second Vice-President of the state society.

In addition to presenting scientific programs at a number of regular meetings, the society had its annual Christmas party for members and invited guests. This has become an important event on the social calendar of this semi-rural county.

The most important item on the list of the year's activities is the graduate course for physicians, sponsored by our society. This is to be held at Warren Hospital, Phillipsburg, in April, 1959.

Our members have served well during the past year in the interest of the local and the state organizations. In the future we plan to do even better.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

April, 1959 • Vol. XXXII—No. 4

AN EVALUATION OF TUBERCULOSIS CASE FINDINGS BY TUBERCULIN TESTING AND SOME OBSERVATIONS OF HISTOPLASMIN SENSITIVITY AMONG YOUNG SCHOOL CHILDREN

Yearly tuberculin and histoplasmin skin tests of young children over a ten-year period show that the prevalence of tuberculin sensitivity remained constant. The examination of contacts of tuberculin reactors continues to be a good case-finding method.

Yearly tuberculin and histoplasmin skin tests among children of the kindergarten and first grades of the public schools in Kansas City, Missouri, have been performed for the past ten years. The present study was directed primarily toward tuberculosis, but since histoplasmosis often presents a problem of differential diagnosis in this area, simultaneous histoplasmin and tuberculin tests were applied.

The purpose of this report is to summarize the results of the ten-year study with particular reference to the annual prevalence rates for tuberculin and histoplasmin sensitivity, conversion rates for these antigens, and to the yield of tuberculosis among the tuberculin reactors as well as among their household and non-household contacts. The results show the correlation of the size of the tuberculin reaction with the yield of tuberculosis. Estimates of the cost of finding tuberculosis by this method are presented.

TUBERCULIN SENSITIVITY UNCHANGED

The results of these studies substantiate those previously reported on the prevalence of tuberculin and histoplasmin sensitivity among kindergarten and first-grade children in the public schools of Kansas City, Missouri.

The prevalence of tuberculin reactors among 35,995 kindergarten children was observed in the ten years between 1947-1957, and a comparison of the prevalence rates for white and Negro children was made. Although there is some variation from year to year, the over-all tuberculin sensitivity rate among Negroes is almost twice that of whites (2.6 per cent versus 1.5 per cent). In contrast, the histoplasmin rates for the entire group are higher for white children than for Negroes (10.4 per cent versus 8.7 per cent).

The tuberculin sensitivity rates were remarkably consistent from year to year and showed no tendency to decline over the entire ten-year period of observation.

During the first few years of this study the histoplasmin prevalence rates among white children were higher than among Negroes, but during the last years were approximately the same. The annual histoplasmin conversion rates, however, were consistently higher among the Negro children.

The section of the city having the highest tuberculin sensitivity rate also had the highest mortality rate, and the section having the lowest sensitivity rate also had the lowest mortality rate.

Among 29,202 white kindergarten children who were classified as nonreactors to tuberculin, there were 500 who showed some induration and erythema at the site of injection but less than the acceptable standard for a positive reaction. There were also 352 children whose test produced only erythema. Among the white children whose reaction was considered positive (induration 5 mm. or more) the measurment of the erythema

LAWRENCE A. WOOD, MICHAEL L. FURCOLOW, AND MYRON J. WILLIS, *American Review of Tuberculosis and Pulmonary Diseases, November, 1958.*

averaged 8 mm. more than that of the induration.

Recently there has been renewed interest in the tuberculin test as a method of tuberculosis case finding. This interest has been stimulated largely by three factors. First, mass roentgenographic surveys become less efficient and more expensive as the tuberculosis case rate diminishes. Furthermore, participation of the eligible age groups is often disappointing. Second, the efficiency of the tuberculin test as a case-finding procedure increases as the general prevalence of tuberculin sensitivity decreases. Recently a third factor of minimizing the exposure to ionizing radiation has been introduced. This study included roentgenograms only of tuberculin reactors and their close contacts and thus represents a fairly high degree of selective roentgenographic exposure.

The youngest of school children were selected for this study because, if tuberculous infection had occurred, it would be relatively recent and their contacts would be limited and easier to follow. The yield of new tuberculosis cases among the children was low, as would be expected, but among the adults there were a surprising number of previously unknown cases of tuberculosis the average being about twelve times that obtained by mass roentgenographic survey. A high percentage of active tuberculosis was found among the previously known cases. Most of these persons had received some form of treatment. Information indicates that the disease was considered inactive in many of these cases and that further follow-up examination had been discontinued either by the patient, his family physician, or the clinic physician. The importance of continued close observation of all known tuberculosis patients is particularly urgent in view of the fact that an accelerated hospital treatment program has been accepted in many communities.

This survey revealed another fact of considerable public health interest. In this community the percentage of children infected with tubercle bacilli at the time of entrance in school is the same now as it was ten years ago. Furthermore, the percentage of children who became infected during their first year in school was relatively high and showed no tendency to decline over the period of seven years' observation. These relatively constant annual tuberculin prevalence and conversion rates should represent a reasonably accurate index of tuberculosis control within the city. There appears to be no ready explanation of the failure of these rates to fall when the death rate for Kansas City has fallen from 31.1 to 11.7 during the ten years of the survey. Reliable morbidity rates are not available.

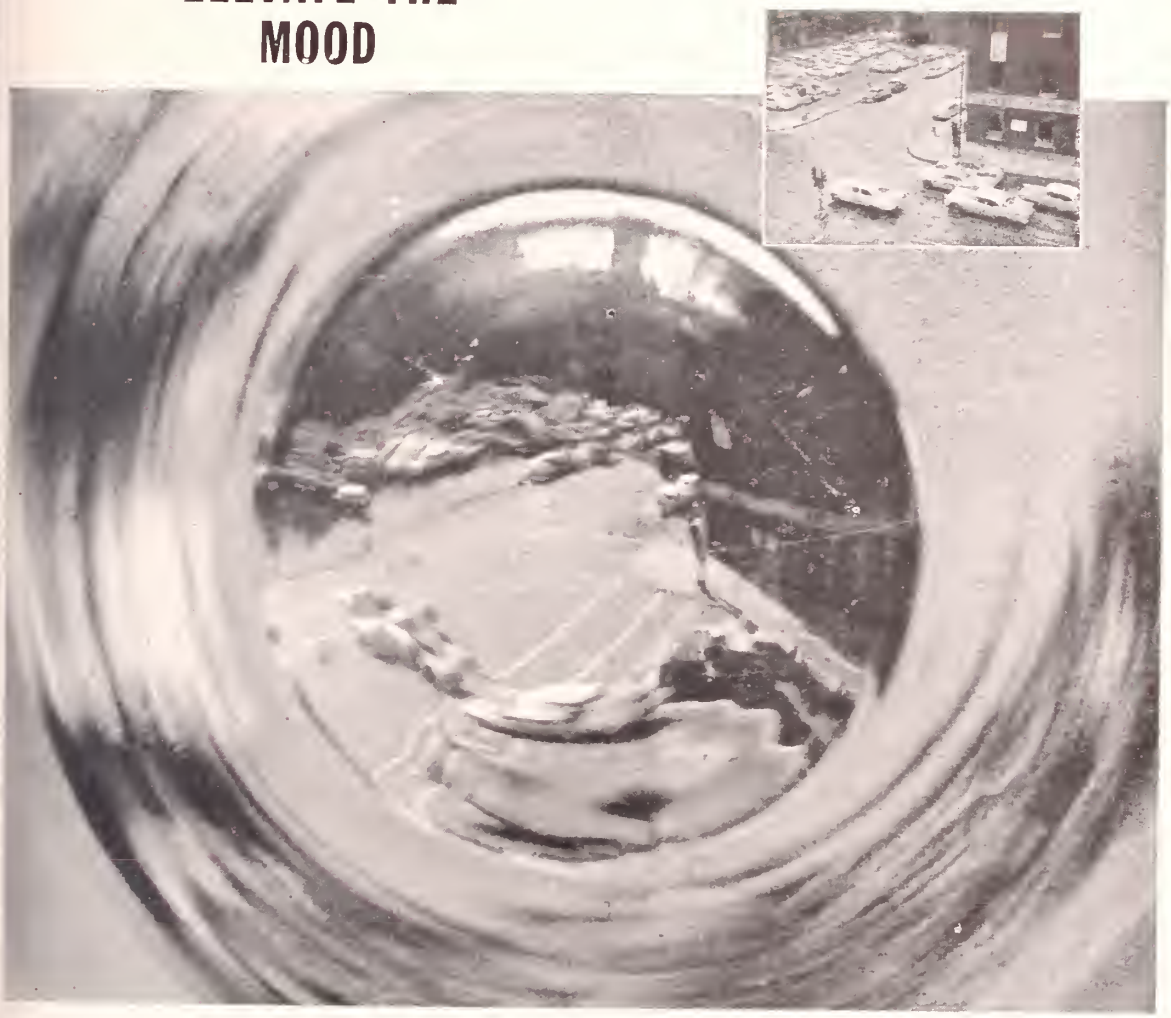
SUMMARY

Some of the most important facts derived from this study are:

1. Tuberculin prevalence rates among children in the kindergarten show no tendency to fall over the ten years of observation either in whites or Negroes.
2. The conversion rates to tuberculin observed in children who were nonreactors in kindergarten do not show a tendency to fall during the seven years' observation.
3. Uses of the tuberculin test for obtaining index children whose contacts form a special risk group for extensive follow-up study not only gives a better yield of tuberculosis cases than mass roentgenography, but at the same time decreases the total exposure of a population to ionizing radiation.
4. The yield of active tuberculosis cases found by follow-up study of contacts of children who are converters was not greater than that found by follow-up study of children who were tuberculin reactors on the first test in kindergarten or first grade.
5. The cost of finding a case of tuberculosis by the methods of this study is about the same for the mass roentgenographic method.

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet 2:347 (Aug. 16) 1958.

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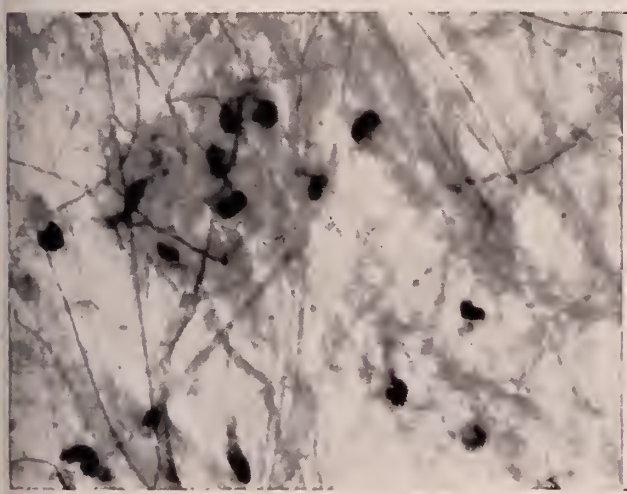
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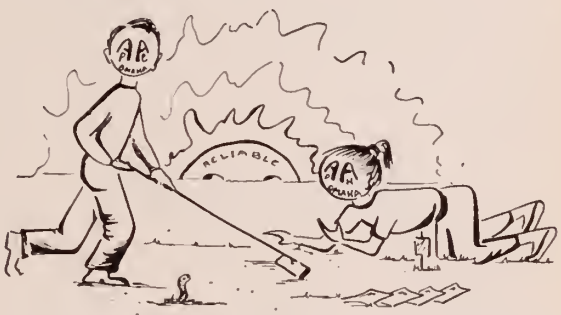
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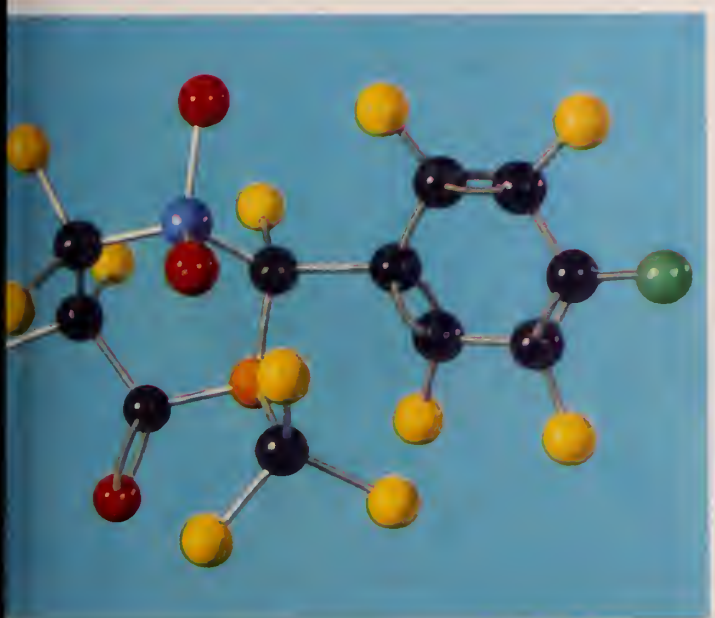
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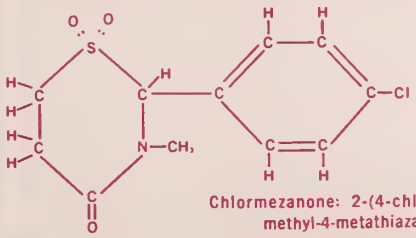
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*** tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



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Thoroughly evaluated clinically...

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

In musculoskeletal conditions[1]

effective in **91%** of patients

INDICATIONS

- Low back pain (lumbago)
- Bursitis
- Osteoarthritis
- Fibrositis
- Myositis
- Postoperative myalgias
- Neck pain (torticollis)
- Rheumatoid arthritis
- Disk syndrome
- Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

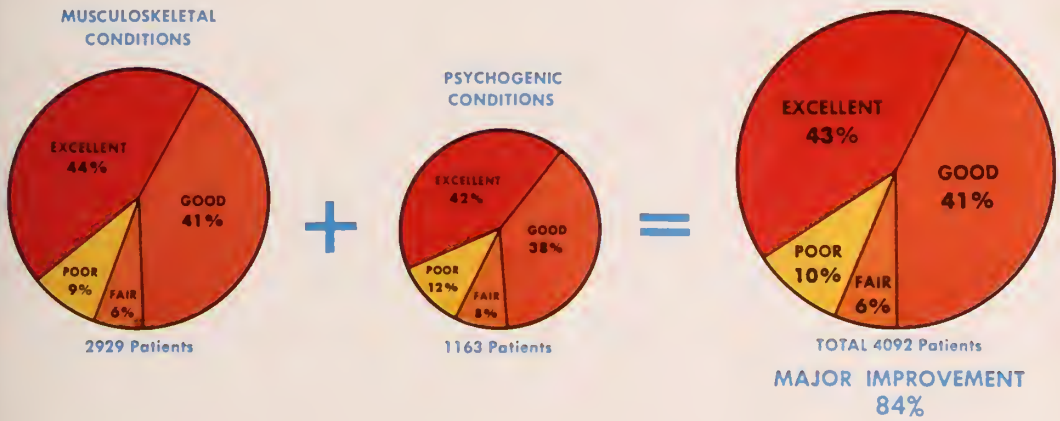
In anxiety and tension states[1]

effective in 88% of patients

INDICATIONS

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "...allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]



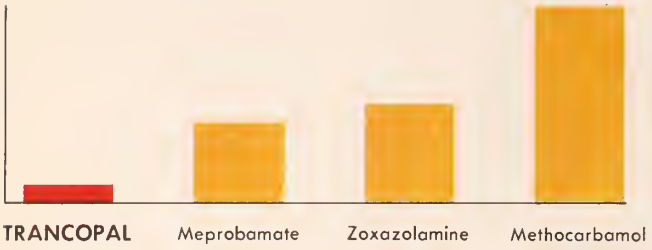
Of the total patients treated, Trancopal produced excellent results in 43 per cent, good results in 41 per cent, fair results in 6 per cent, and poor results in 10 per cent.

Better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage.
Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

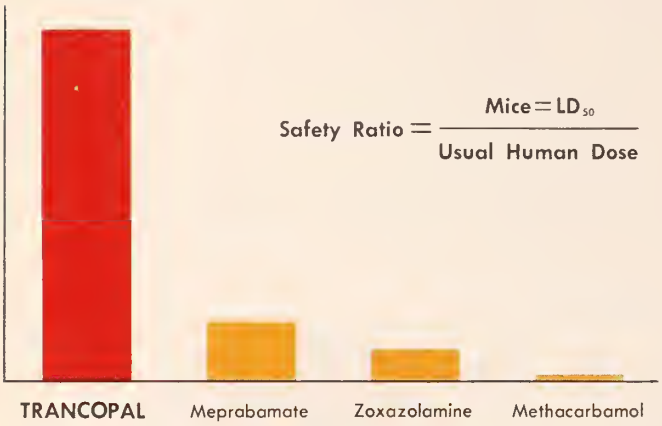
Comparison with 3 widely used central relaxants

When compared with three widely used central relaxants for activity, safety and clinical effectiveness, Trancopal offers definite desirable advantages.



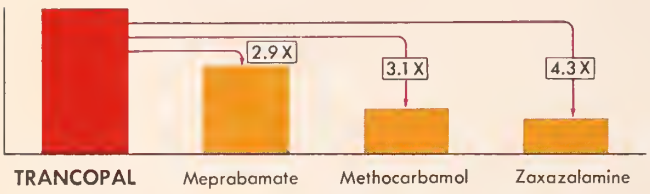
for activity

In the usual human dose, Trancopal is four to te times as potent per milligram.



for safety

Comparative pharmacologic tests showed tha Trancopal is up to thirteen times as safe or up t thirteen times less toxic. The measure of safet was the LD_{50} in mice/usual human dose.



for clinical effectiveness

A clinical comparison in low back pain, torticollis bursitis and anxiety states showed that Trancop is up to four times as effective. Each of the 4 patients received all four drugs in random rot tion for several days. Although each of the fou gave some relief, only the one providing the mos effective relief was recorded.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. · 2. Gans, S.E.: To be published. · 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

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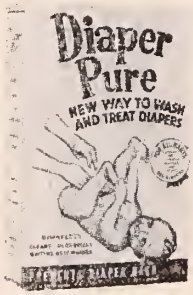
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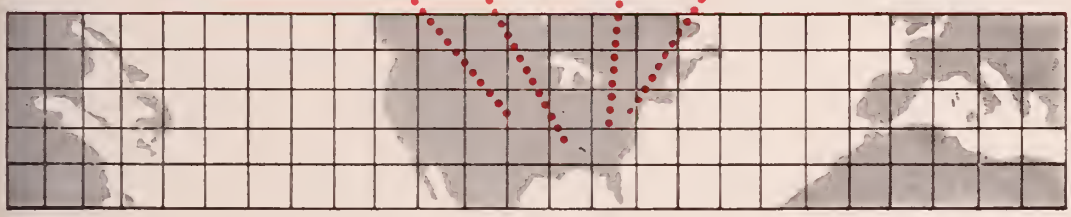
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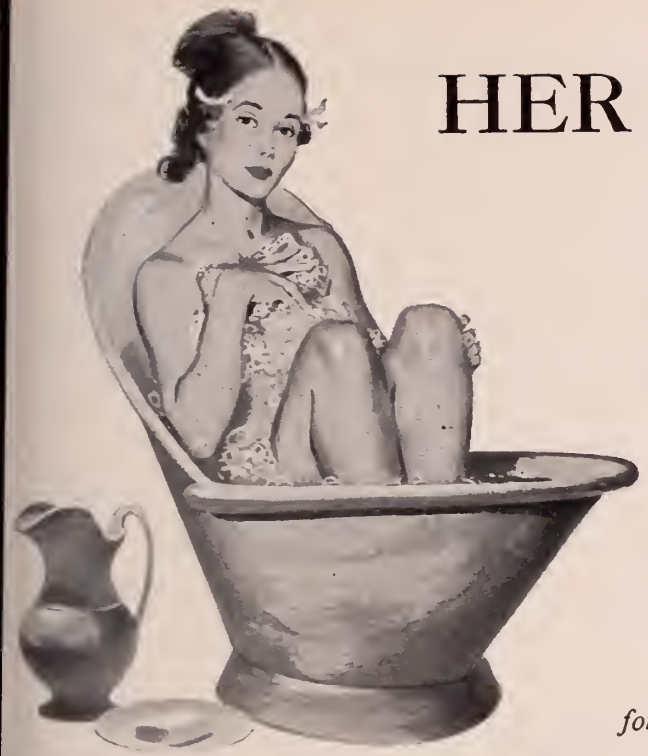
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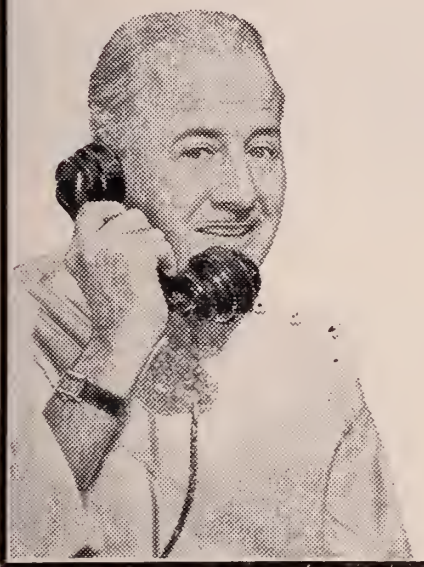
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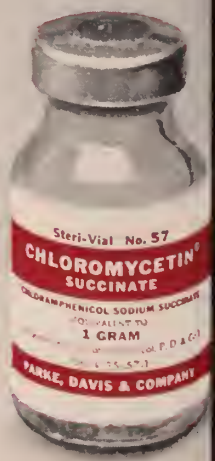
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Shigella dysentery	14	14		
Enteritis	10	6	2	2
Bacteremia	5	5		
Meningitis**	4	3		1
Rocky Mountain spotted fever	2	2		
Ear abscess with cellulitis	1	1		
Lung abscess	1			1
Typhoid fever	1	1		
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CONTENTS—Pages 223 to 296

EDITORIALS— Page

Meet Clyde Bowers 223
Pharmaceuticals of 1958 224
The Servant of Medicine 225
Television Medicine 225

ORIGINAL ARTICLES—

Pulmonary Tuberculosis—David Biber, M.D., Union, N. J. 226

Tetanus: A Current Appraisal—Bernard H. Chaiken, M.D., W. A. Tansey, M.D., Short Hills, N. J. and Alan L. Jacobs, M.D., Union, N. J. 232

Practical Aspects of Iron Metabolism—Murray Nussbaum, M.D., Jersey City, N. J. 237

Positron Brain Scanner and Intracranial Lesions—Elliot Rinzler, M.D., Wade N. Miller, M.D. and Lillian E. Jacobson, M.A., Newark, N. J. 243

Alcoholism Treated with Prochlorperazine—George A. Rogers, M.D., Camden, N. J. 247

Methyl Salicylate Poisoning—Donald P. Burt, M.D., Morristown, N. J. 251

Meprobamate in Mentally Retarded Cerebral Palsy—Miles E. Drake, M.D., Ph.D., Vineland, N. J. 256

ORIGINAL ARTICLES— Page

Arrhythmias in Myocardial Infarction—Alvin A. Rosenberg, M.D., Morristown, N. J. 258

Antihistamine Poisoning—Henry A. Connolly, Jr., M.D., Summit, N. J. 264

SPECIAL ARTICLE—

The Ever-Changing Practice of Medicine—Kenneth E. Gardner, M.D., Bloomfield, N. J. 266

HISTORICAL ARTICLE—

William Augustus Newell—Physician, Governor, Congressman—Fred B. Rogers, M.D., Trenton, N. J. 278

STATE ACTIVITIES—

Trustees' Meeting 282
Hospitalization Survey 282
Mental Hospital Programs 283
Lymphoma-Leukemia Study 284
Glaucoma Identification Card 284

OBITUARIES 285
CIVIL DEFENSE ITEMS 286
ANNOUNCEMENTS 287
COUNTY SOCIETY REPORTS 288
WOMAN'S AUXILIARY 292
BOOK REVIEWS 293
NTA ABSTRACTS 295

Roster of Officers, Page 3A

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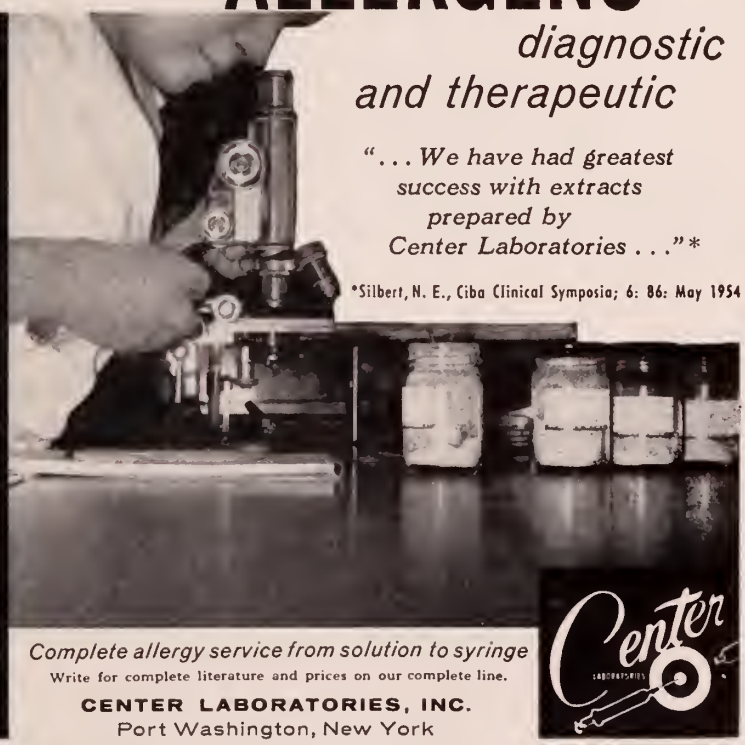
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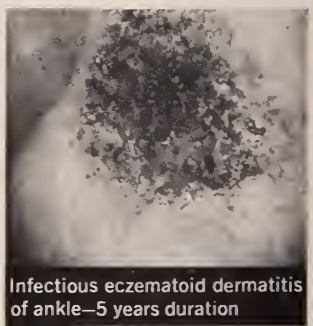


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side reactions — side reactions produced by DBI are chiefly gastrointestinal and occur with increasing frequency at higher dosage levels (exceeding 150 mg. per day). Anorexia, nausea or vomiting may occur — but these symptoms abate promptly upon reduction in dose or withdrawal of DBI.

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IMPORTANT — before prescribing DBI the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects, precautions and contraindications, etc. Write for complete detailed literature.

an original development from the research laboratories of

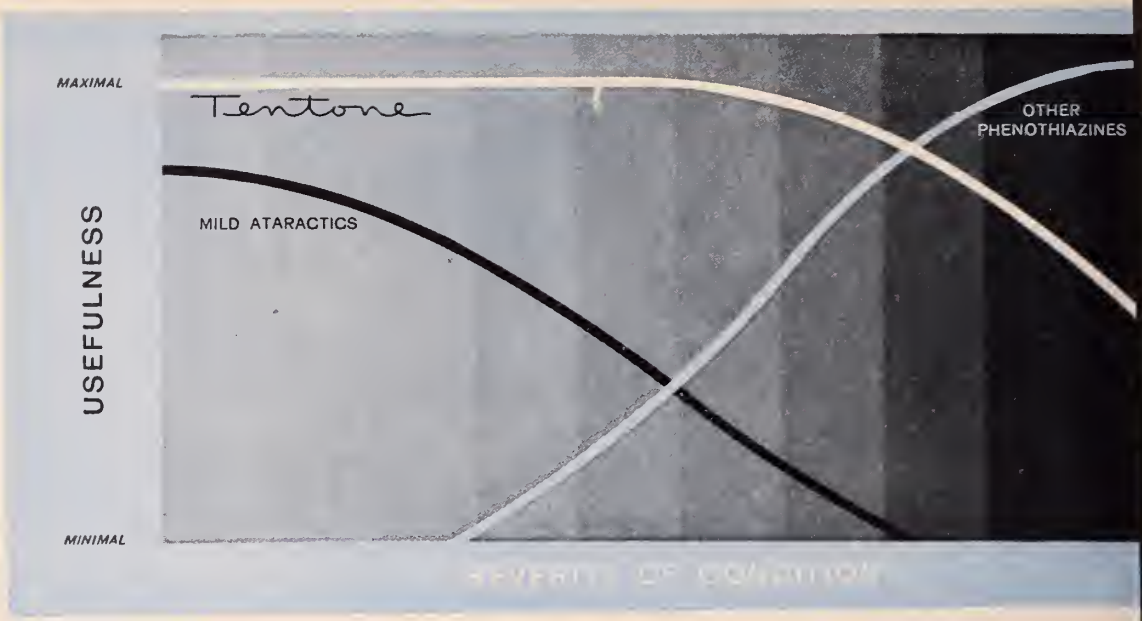
u.s. vitamin & pharmaceutical corporation

Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N.Y.

ANNOUNCING



A HIGHLY EFFECTIVE TRANQUILIZER FOR EXTENDED OFFICE PRACTICE USE



POSITIVE CALMING ACTION ADAPTED FOR LOWER RANGE OF EMOTIONAL DISORDERS

The development of TENTONE® Methoxypromazine Maleate *Lederle* does not duplicate primary function of existing tranquilizers. TENTONE fills the need for a practical, potent agent for extended use in everyday practice (as illustrated above).

Action of TENTONE Methoxypromazine Maleate approaches that of the strong phenothiazines without their drawbacks. Calming response is positive and rapidly apparent to both patient and physician. However, as a basic phenothiazine modification, TENTONE allows full therapeutic application in the mild and moderate range of anxiety-tension and somapsychic disorders most usually seen in general practice.

EXCELLENT TOLERATION—MARKED REDUCTION IN COMPLICATIONS

Incidence of untoward reactions is exceptionally low and approximates the mild ataractic drugs. Reduction in sensitivity reaction, intestinal distress, blood, brain or liver toxicity is striking, particularly in the low dosage range. TENTONE exhibits greater freedom from depression and drug habituation. Physical and psychic orientation is usually preserved. Occasional drowsiness may be encountered, particularly in higher dosages. In moderate to more severe cases, this sedative effect may be desired.

TENTONE has thus been described as one of the easiest tranquilizers to handle in office practice. In indicated cases, the physician may be relieved of the patient's unnecessary concern over his own illness. In contrast to the previous types of drugs, complaints over induced distress or inadequate benefit are rare.

WHEN MORE THAN MILD SEDATIVE EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesis ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE POTENTIATION OF ANALGESICS AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE LOWER DOSAGE RANGES

Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

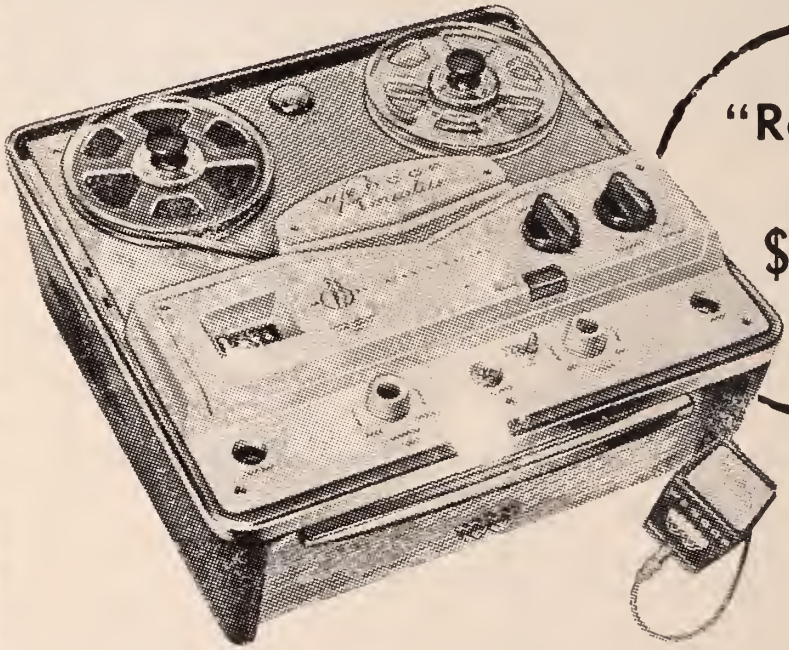
Supplied: 10 mg., 25 mg. and 50 mg. tablets



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REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



Reaching for 9B shoes and other top shelf sizes is no joke . . . it gave me a terrible kink in my back.



Before the day was over, I could hardly stoop to push a shoehorn.



I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

Percodan®-Demi & Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

ACTS FASTER — usually within 5-15 minutes. **LASTS LONGER** — usually 6 hours or more. **MORE THOROUGH RELIEF** — permits uninterrupted sleep through the night. **RARELY CONSTIPATES** — excellent for chronic or bedridden patients. **VERSATILE** — new "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

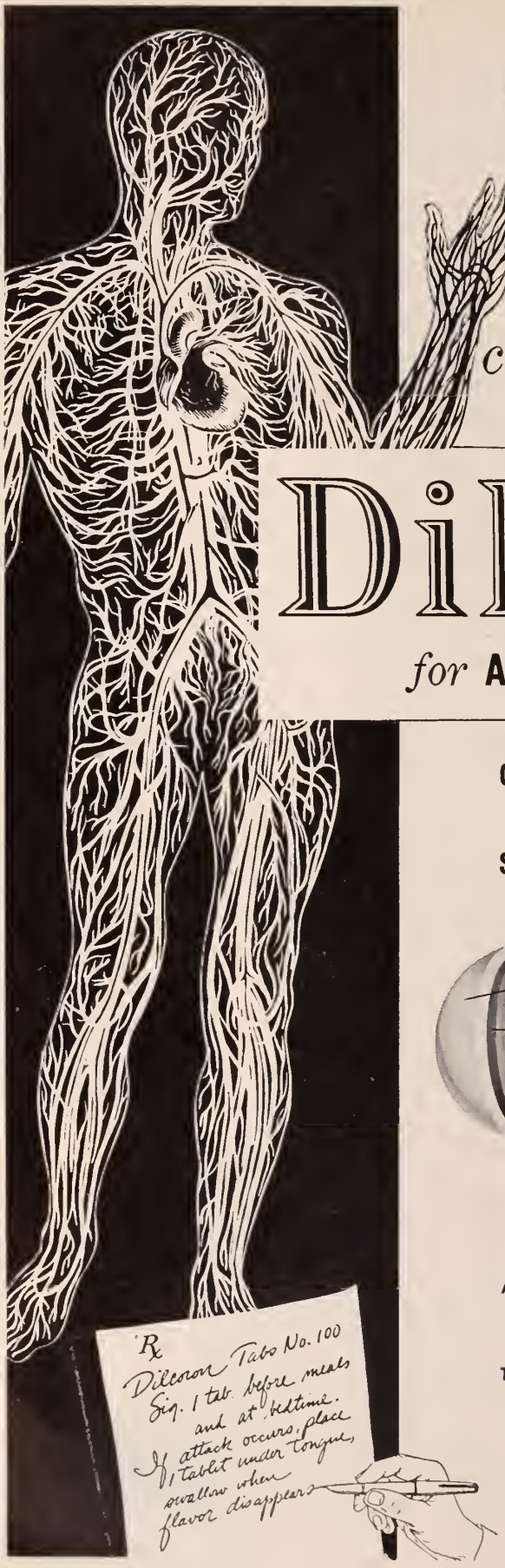
Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

AND THE PAIN WENT AWAY FAST

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,628,185



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"flavor-timed"
dual-action
coronary vasodilator

Dilcoron®

for **ANGINA PECTORIS**

ORAL *(tablet swallowed whole)*
for dependable prophylaxis

SUBLINGUAL-ORAL
for immediate and sustained relief



Nitroglycerin
—0.4 mg. (1/150 grain)—acts quickly

Citrus "flavor-timer"
—signals patient when to swallow

Pentaerythritol tetranitrate
—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet on an empty stomach.

Bottles of 100.

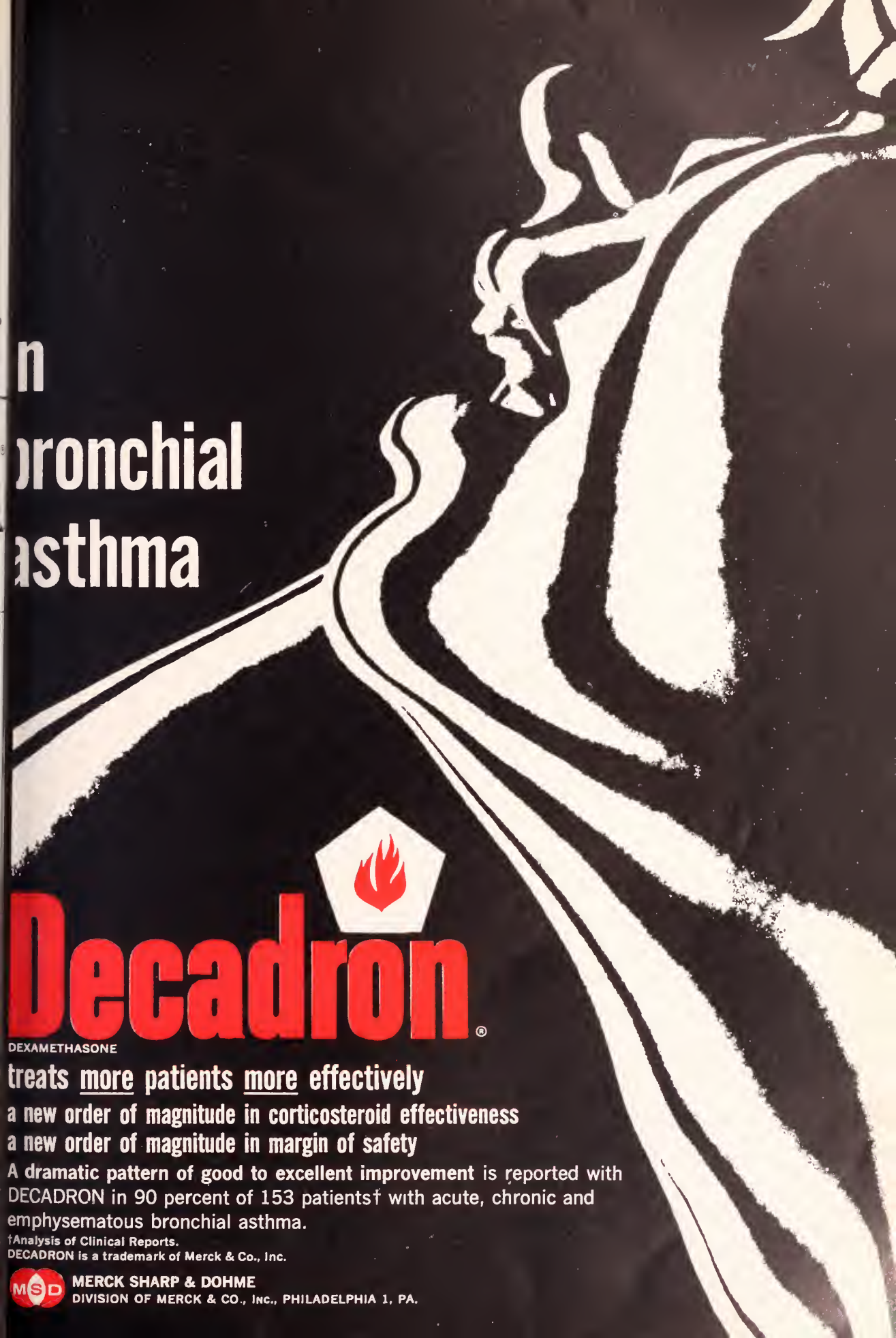
Average prophylactic dose:

1 tablet four times daily
(½ hour before meals and at bedtime).

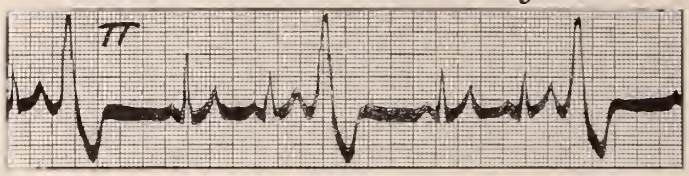
Therapeutic dose:

1 tablet held under the tongue until citrus flavor disappears, then swallowed.

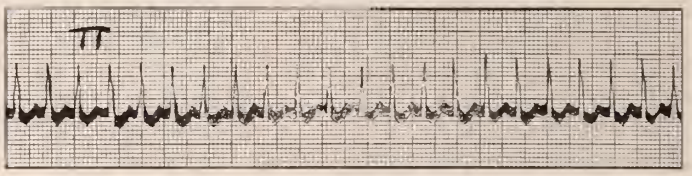
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NEW YORK 18, N. Y.


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Decadron®
DEXAMETHASONE
treats more patients more effectively
a new order of magnitude in corticosteroid effectiveness
a new order of magnitude in margin of safety
A dramatic pattern of good to excellent improvement is reported with DECADRON in 90 percent of 153 patients† with acute, chronic and emphysematous bronchial asthma.
†Analysis of Clinical Reports.
DECADRON is a trademark of Merck & Co., Inc.
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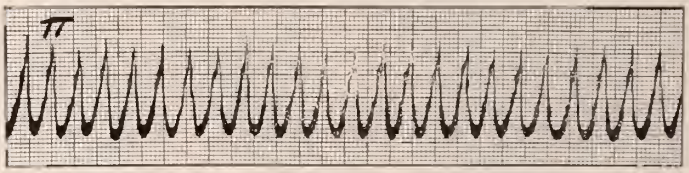
restore normal sinus rhythm



1. Premature ventricular contractions



2. Paroxysmal auricular tachycardia



3. Paroxysmal ventricular tachycardia

in arrhythmias

VISTARIL

hydroxyzine pamoate *

More than a tranquilizer

SPECIFIC ANTIARRHYTHMIC EFFECT

Vistaril is effective in ventricular extrasystoles and paroxysmal tachycardias (both auricular and ventricular).

plus

PSYCHOTHERAPEUTIC POTENCY

proven calming action indicated for arrhythmia patients.

and

THE OUTSTANDING SAFETY

of Vistaril as compared to other antiarrhythmic drugs in general use has been noted by investigators.

THE FOLLOWING DOSAGE REGIMEN IS RECOMMENDED

(individualized by the physician for maximum effectiveness):

PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h., p.r.n.; maintain with 25 mg. b.i.d. or t.i.d. In acute emergency, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h., p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

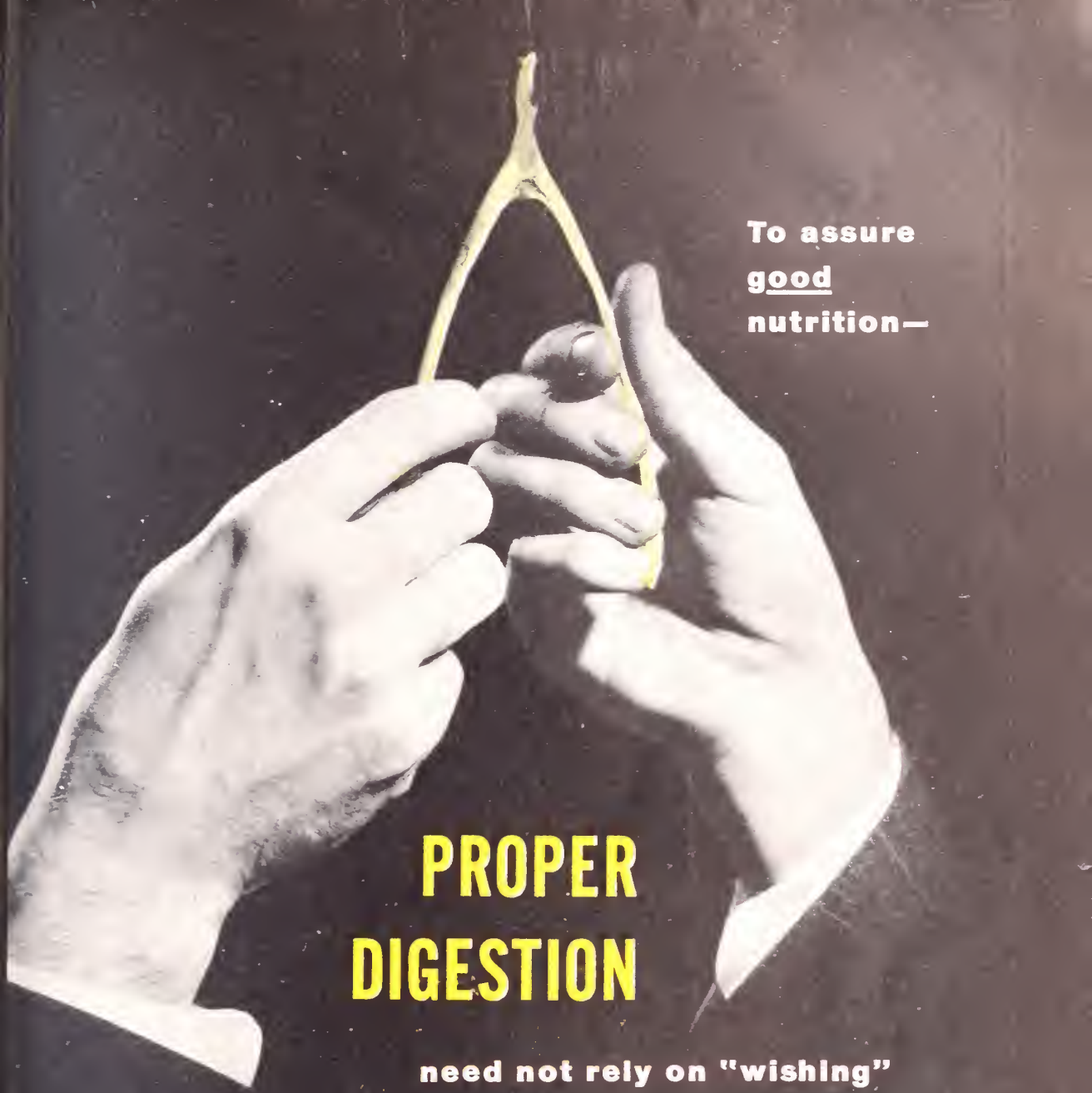
SUPPLY: Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. (as the hydrochloride).

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

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References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.



To assure good nutrition—

PROPER DIGESTION

need not rely on "wishing"

Each double-layered Entozyme tablet contains:

Pepsin, N.F. ..... 250 mg.
—released in the stomach from gastric-soluble outer coating of tablet.

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Bile Salts ..... 150 mg.
—released in the small intestine from enteric-coated inner core.

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Ethical Pharmaceuticals of Merit since 1878

As a comprehensive supplement to deficient natural secretion of digestive enzymes, particularly in older patients, ENTOZYME effectively improves nutrition by bridging the gap between adequate ingestion and proper digestion. Among patients of all ages, it has proved helpful in chronic cholecystitis, post-cholecystectomy syndrome, subtotal gastrectomy, pancreatitis, dyspepsia, food intolerance, flatulence, nausea and chronic nutritional disturbances.

For comprehensive digestive enzyme replacement—

ENTOZYME®

Robins


New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

SQUIBB *Squibb Quality—the Priceless Ingredient*

"Delalutin"® is a Squibb trademark


No
turned-up noses
at this
new Erythrocin
suspension

a new derivative of Erythromycin designed especially for children

CITRUS-FLAVORED

ERYTHROCIN®

ETHYL SUCCINATE

ORAL SUSPENSION

Never a flavor like this in an antibiotic suspension. A new achievement in pharmaceutical elegance—a ready-mixed, stable suspension so sweet and good you can't tell it's "medicine."

No bitterness, no unpleasant aftertaste—just pure, sweet citrus flavor.

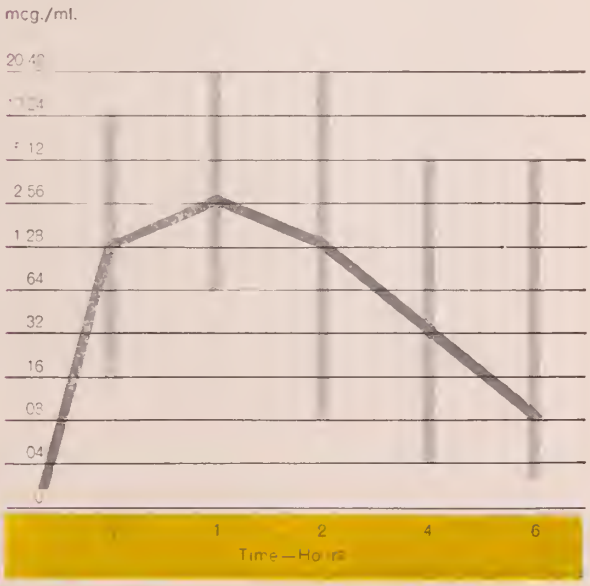
Never an antibiotic better proved against everyday coccal infections. After millions of prescriptions, an unparalleled safety record.

High, peak blood levels within one hour—plus nearly 100% effectiveness against coccal infections. And, unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal agent.

Indications: Against staph-, strep- and pneumococci. Especially useful when patients are allergic to penicillin or other antibiotics. **Dosage:** For children, 30 mg./Kg. per day. Adults, 1 to 2 Gm., depending on severity of infection. **Supplied:** In 60-cc., pour-lip bottles. Each 5-cc. teaspoonful, represents 200 mg. of Erythrocin. Abbott

If you're concerned with blood levels . . .

Range of blood levels obtained from one dose of 400 mg. ERYTHROCIN SUSPENSION. Medication was administered to 30 volunteer adults, and represents a dosage of approximately 6 mg./Kg. Bars show ranges—continuous line indicates medians.



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in cases of tension

Serpate®

(Reserpine, Vale)

. . . the preferred drug where anxiety or emotional agitation must be controlled

. . . provides sedation without hypnosis, a sense of relaxed well being and tranquility

. . . effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies



in cases of hypertension

Rauval®

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. . . double assayed to insure optimal therapeutic effect

tested chemically to insure total alkaloid content

tested biologically to insure uniform hypotensive action

. . . ideal therapy in labile and moderate hypertension or as adjunctive therapy in severe hypertension

. . . achieves gradual lowering of the blood pressure, gentle sedation, tranquilization with prolonged effect even after cessation of therapy

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Merwick, the Elsie Procter Matthews Unit of Princeton Hospital, is a pioneer medical undertaking in the state of New Jersey. Designed specifically for geriatric cases and the chronically ill of all ages (except pediatric cases), it is the first long-term nursing facility in the State directly operated by a general hospital.

The chief purpose of Merwick is to provide an attractive home, complete with all the facilities which make up a well-rounded life within the physical limitations of its guests, while adding the important factors of skilled medical supervision and nursing care.

Designed to house 42 guests, the Unit has the same non-profit status as does the Hospital itself. It functions under the direct supervision of the Hospital administration, with a Hospital Staff physician in charge of medical services.

With nine beautifully landscaped acres surrounding it, Merwick provides a home of rare beauty and quiet and has many unusual facilities available for the comfort and convenience of residents. Brochure available. Rates on request.

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New Neocurtasal embodies the characteristic tang, grain and texture of regular table salt. Now whether food is seasoned by New Neocurtasal or salt — few patients detect the difference. Insipid dishes are rendered more palatable, tiresome diets less exacting.

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NEW **Neocurtasal**® *"An Excellent Salt Replacement"*

— available in convenient 2 oz. shakers and 8 oz. bottles.



Contains patassium chlaride, patassium glutamate, glutamic acid, calcium silicate, potassium iadide (0.01%).

When Diuresis Is a "Must"—

SALYRGAN®-THEOPHYLLINE

Parenteral • Oral

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Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

CM-8623

THE HEART DISEASE PATIENT NEEDS RELIEF FROM EMOTIONAL STRESS



ANXIETY INTENSIFIES the physical disorder in heart disease. "The prognosis depends largely on the ability of the physician to control the anxiety factor, as well as the somatic disease."

(Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Cardiol. 1:395, March 1958.)

TRANQUILIZATION WITH MILTOWN enhances recovery from acute cardiac episodes and makes patients more amenable to necessary limitations of activities.

(Waldman, S. and Pelner, L.: Management of anxiety associated with heart disease. Am. Pract. & Digest Treat. 8:1075, July 1957.)

Miltown®

meprobamate (Wallace)

Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules). In combination with a nitrate, for angina pectoris: MILTRATE* (Miltown 200 mg. + PETN 10 mg.).

Miltown causes no adverse effects on heart rate, blood pressure, respiration or other autonomic functions.

*TRADE-MARK CM-8275

WALLACE LABORATORIES, *New Brunswick, N. J.*

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

‡ **ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.**

NATIONAL CASUALTY COMPANY
through
E. and W. BLANKSTEEN

NATIONWIDE MUTUAL INSURANCE CO.
through
E. and W. BLANKSTEEN AGENCY, Inc.

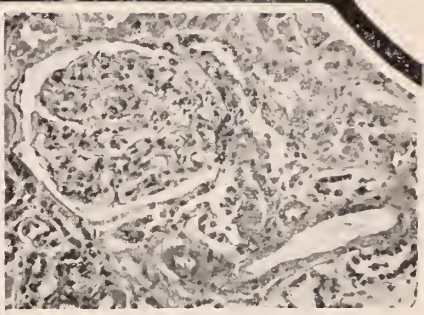
75 MONTGOMERY STREET **DELAWARE 3-4340** **JERSEY CITY 2, N. J.**

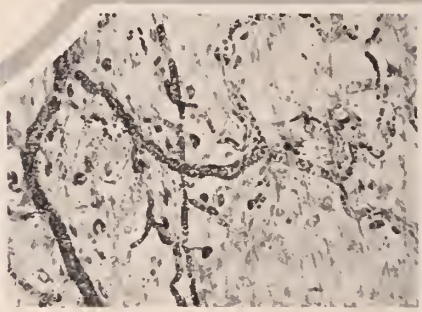
SQUIBB ANNOUNCES

NEW

RAUTRAX

RAUDIXIN
Squibb Standardized
Whole Root Rauwolfia Serpentina
FLUMETHIAZIDE
POTASSIUM CHLORIDE





A LOGICAL COMBINATION **RAUDIXIN** ENHANCED
BY AN ENTIRELY NEW DIURETIC — **FLUMETHIAZIDE**

THUS SQUIBB OFFERS YOU GREATER LATITUDE IN SOLVING THE PROBLEM OF

HYPERTENSION

WITHOUT FEAR OF SIGNIFICANT POTASSIUM DEPLETION[1-3]

Rautrax combines Raudixin with flumethiazide — *the new, safe nonmercurial diuretic* — for control of all degrees of hypertension. Clinicians report it safely and rapidly eliminates excess extracellular sodium and water without potassium depletion.[1-3] Potassium loss is less than with any other nonmercurial diuretic.[1] Moreover, the inclusion of supplemental potassium chloride in Rautrax provides added protection against potassium and chloride depletion in the long-term management of hypertension.

Through this dependable diuretic action of flumethiazide, the clinical and subclinical edema — so often associated with cardiovascular disease — is rapidly brought under control.[2-5] And once Rautrax has brought the fluid balance within normal limits, continued administration does not appreciably alter the normal serum electrolyte pattern. Flumethiazide also potentiates the antihypertensive action of Raudixin. By this unique dual action, a lower dosage of each ingredient effectively maintains safe antihypertensive therapy.

Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.

Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.

References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, *4*:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

LITERATURE AVAILABLE ON REQUEST.

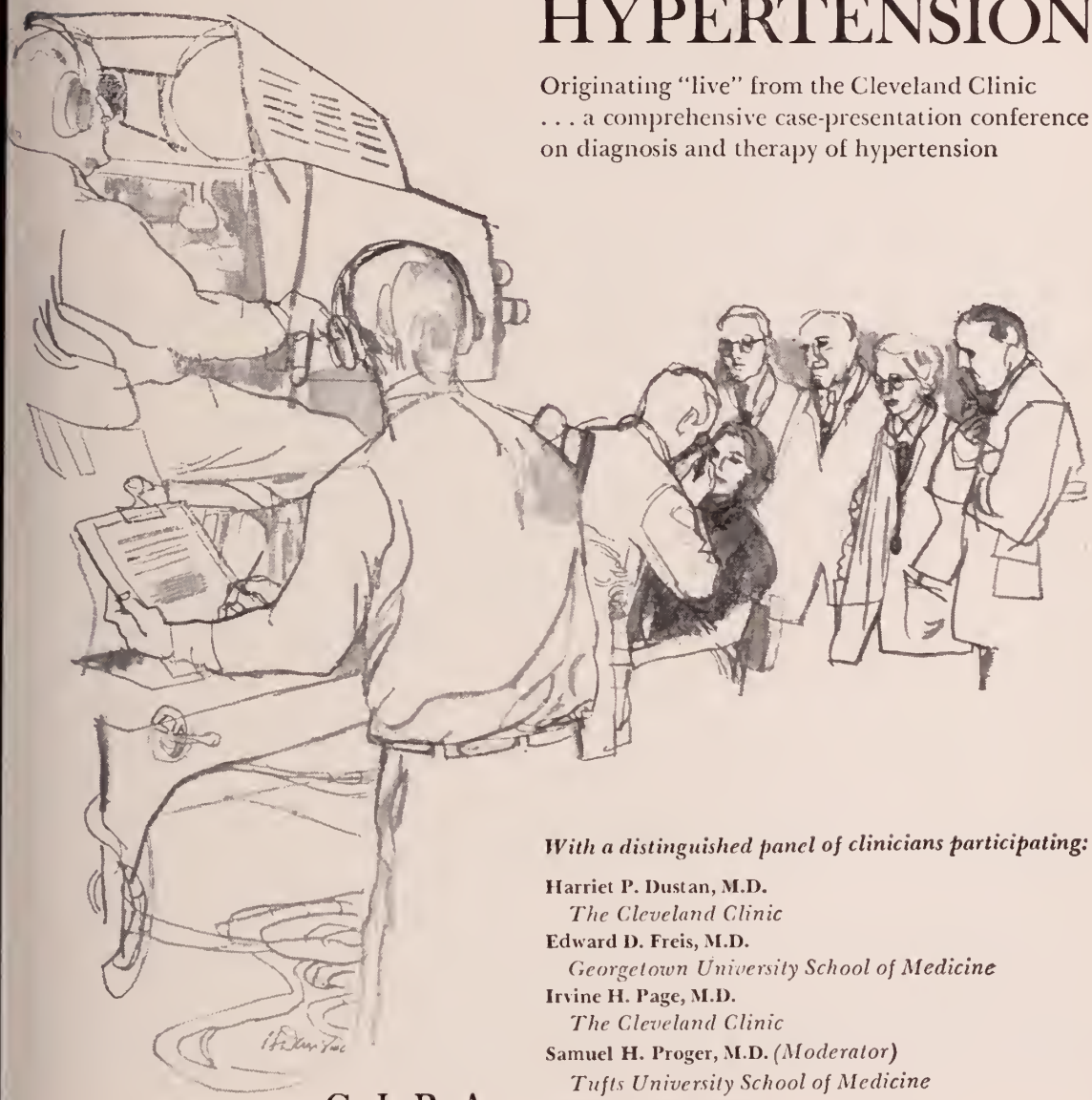
'RAUDIXIN' AND 'RAUTRAX' ARE SQUIBB TRADEMARKS

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Georgetown University School of Medicine
Irvine H. Page, M.D.
The Cleveland Clinic
Samuel H. Proger, M.D. *(Moderator)*
Tufts University School of Medicine
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9 P.M.	Baltimore, Md.
9 P.M.	Boston, Mass.
9 P.M.	Brooklyn, N. Y.
8 P.M.	Chicago, Ill.
9 P.M.	Cleveland, Ohio
6 P.M.	Denver, Colo.
8 P.M.	Detroit, Mich.
9 P.M.	Garden City, N. Y.
7 P.M.	Kansas City, Mo.
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Doctors, too, like "Premarin"

THE doctor's room in the hospital is used for a variety of reasons. ost any morning, you will find the ternist talking with the surgeon, e resident discussing a case with e gynecologist, or the pediatrician for a cigarette. It's sort of a club, is room, and it's a good place to t the low-down on "Premarin"

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural es-

is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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when it's skin deep

use XYLOCAINE *ointment*

. . . in nearly all external symptoms of *pain*, *itching* and *burning*, e.g., sunburn, minor burns, insect bites, abrasions, poison ivy and other contact dermatitis, hemorrhoids and inoperable anorectal conditions, and cracked nipples.

Xylocaine Ointment, a surface or topical anesthetic, gives fast, effective and long lasting relief. Its *water-soluble*, *nonstaining* base melts on contact with the skin, to assure immediate release of the anesthetic for fast action and it does not interfere with the healing processes.

ASTRA PHARMACEUTICAL PRODUCTS, INC., WORCESTER 6, MASS., U.S.A.

XYLOCAINE® OINTMENT

(brand of lidocaine*)

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SURFACE ANESTHETIC

U.S. Pat. No. 2,441,498 Made in U.S.A.

2½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

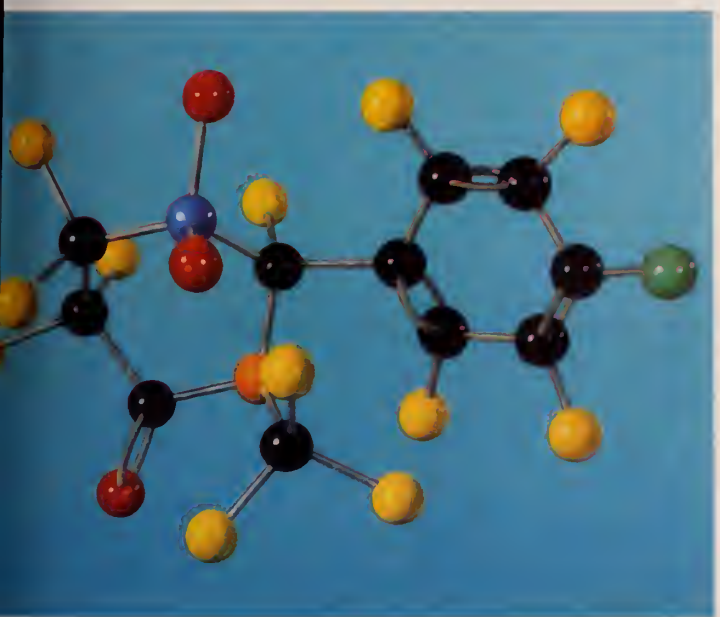
Trancopal®

*the first true tranquilaxant**

***Potent* MUSCLE RELAXANT**

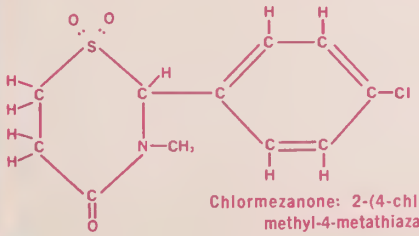
***...Equally effective as a* TRANQUILIZER**

*** tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Thoroughly evaluated clinically...

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

In musculoskeletal conditions[1]

effective in 91% of patients

INDICATIONS

- Low back pain (lumbago)
- Bursitis
- Osteoarthritis
- Fibrositis
- Myositis
- Postoperative myalgias
- Neck pain (torticollis)
- Rheumatoid arthritis
- Disk syndrome
- Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

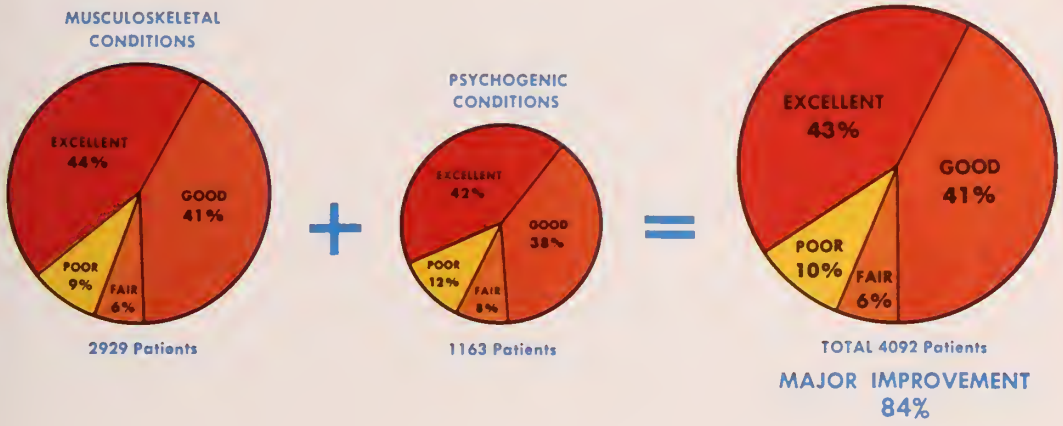
In anxiety and tension states[1]

effective in 88% of patients

INDICATIONS

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "...allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]



Of the total patients treated, Trancopal produced excellent results in 43 per cent, good results in 41 per cent, fair results in 6 per cent, and poor results in 10 per cent.

Better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

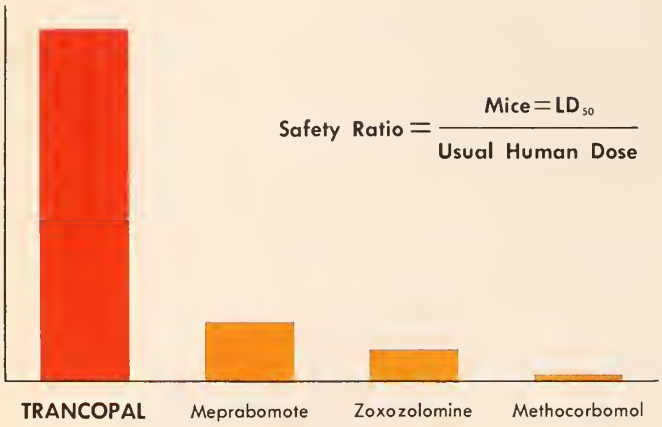
Comparison with 3 widely used central relaxants

When compared with three widely used central relaxants for activity, safety and clinical effectiveness, Trancopal offers definite desirable advantages.



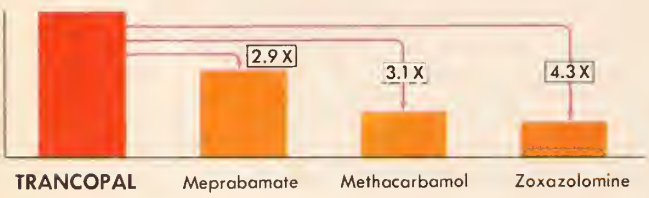
for activity

In the usual human dose, Trancopal is four to ten times as potent per milligram.



for safety

Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



for clinical effectiveness

A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of the 40 patients received all four drugs in random rotation for several days. Although each of the four gave some relief, only the one providing the most effective relief was recorded.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. • 2. Gans, S.E.: To be published. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

the first true tranquilaxant

Trancopal

Potent
MUSCLE RELAXANT
...Equally effective as a
TRANQUILIZER

Winthrop Laboratories / New York 18, New York

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off.

Printed in U. S. A. 3-59 (40

RESEARCH:

key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

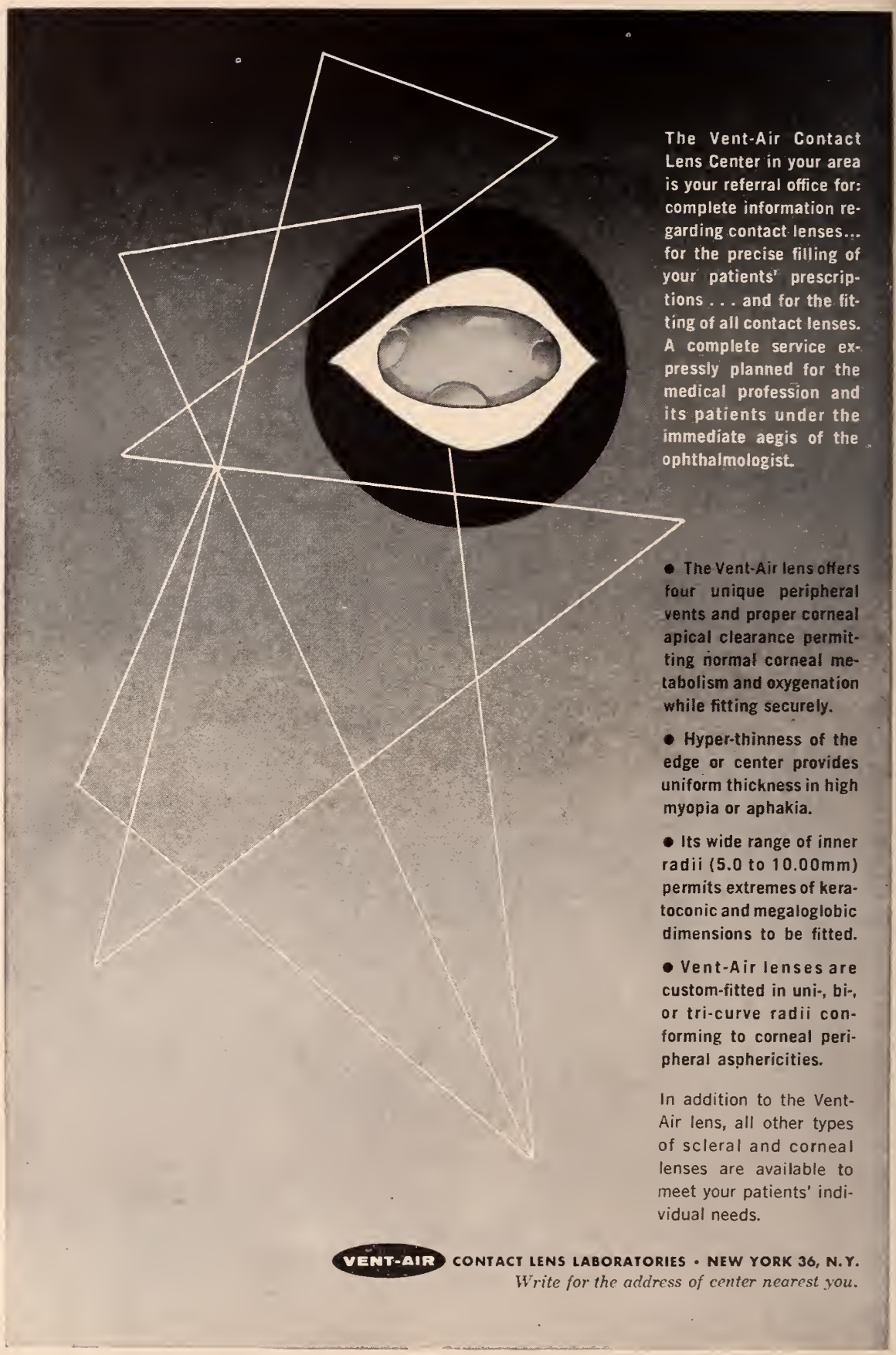
These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have been previously described in these pages

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.



The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!



The Vent-Air Contact Lens Center in your area is your referral office for: complete information regarding contact lenses... for the precise filling of your patients' prescriptions . . . and for the fitting of all contact lenses. A complete service expressly planned for the medical profession and its patients under the immediate aegis of the ophthalmologist.

- The Vent-Air lens offers four unique peripheral vents and proper corneal apical clearance permitting normal corneal metabolism and oxygenation while fitting securely.
- Hyper-thinness of the edge or center provides uniform thickness in high myopia or aphakia.
- Its wide range of inner radii (5.0 to 10.00mm) permits extremes of keratoconic and megaloglobic dimensions to be fitted.
- Vent-Air lenses are custom-fitted in uni-, bi-, or tri-curve radii conforming to corneal peripheral asphericities.

In addition to the Vent-Air lens, all other types of scleral and corneal lenses are available to meet your patients' individual needs.

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Write for the address of center nearest you.



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol.** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

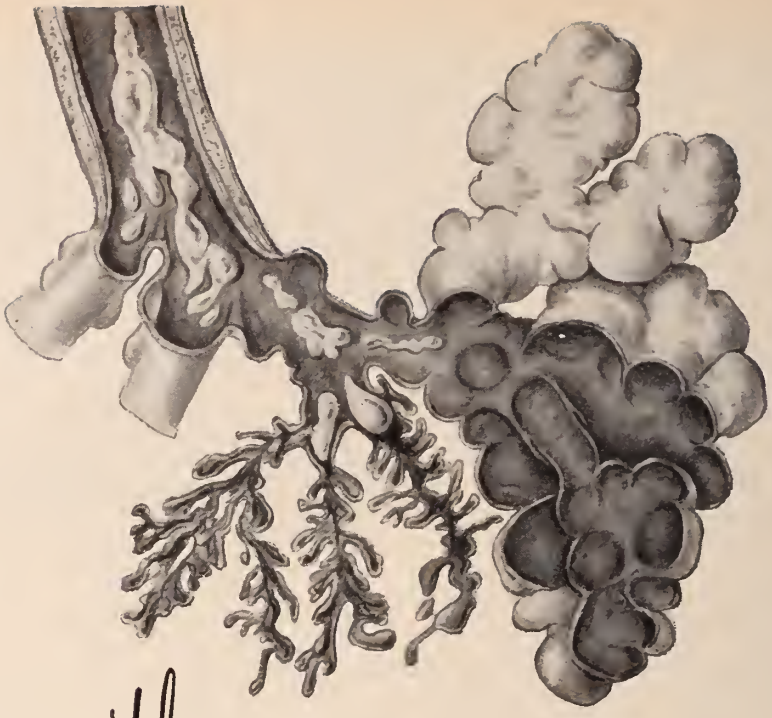
Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn



Clear the air

with ALEVAIRE®

inhalation therapy

WETS, THINS, LOOSENS PULMONARY SECRETIONS

Very useful in...

... BRONCHITIS
BRONCHIAL ASTHMA
BRONCHIECTASIS
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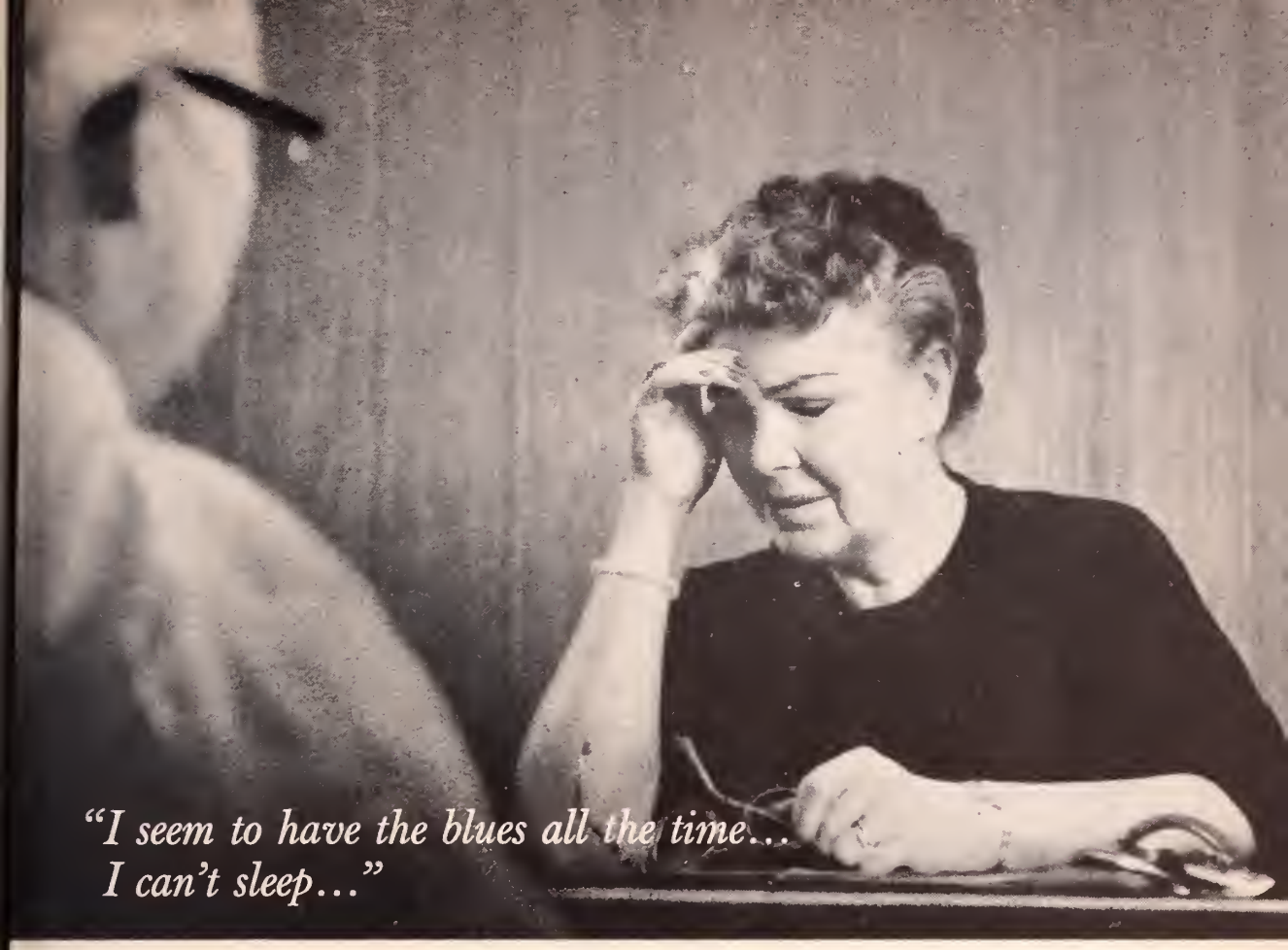


Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Alevaire, trademark reg. U.S. Pat. Off.



in the depressed, unhappy patient

PROMPTLY IMPROVES MOOD

without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.



EFFICACY AND SAFETY CONFIRMED IN OVER 3,000 DOCUMENTED CASE HISTORIES.[1, 2, 3]

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each light-pink, scored tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

References:
1. Alexander, L. J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M., Am. J. Psychiat. 115:250, Sept. 1958.

for depression

▲Deprol▲†

®WALLACE LABORATORIES, *New Brunswick, N. J.*

†TRADE-MARK

CD-9050

HIGHLIGHTS FROM THE A.M.A. COUNCIL ON DRUGS

REPORT ON TRIAMCINOLONE

J.A.M.A. 169:257 (January 17) 1959.

"It [triamcinolone] has an anti-inflammatory potency greater than an equal amount of prednisolone; i.e., comparable suppressive effects may usually be achieved with lower doses of triamcinolone than with prednisolone."

"Triamcinolone lacks the sodium-retaining and edema-producing effects of most other glucocorticoids. During the first several days of administration, it may cause a loss of sodium from the body; an initial mild diuretic action is frequently observed, whether the patient is frankly edematous or not. This is in contrast to the definite sodium-retaining and fluid-retaining properties of cortisone and hydrocortisone and to a much lesser extent with prednisone and prednisolone."

"Except in exceedingly large doses, triamcinolone apparently has no consistent effect on potassium excretion. Hence, neither sodium restriction nor potassium supplementation is ordinarily required during therapy with this agent."

"As with other glucocorticoids, the long-term administration of triamcinolone results in definite catabolic effects, as indicated by impairment of carbohydrate utilization and negative protein and calcium balance. This catabolic effect, coupled with a lack of appetite stimulation which is apparently peculiar to triamcinolone, may produce weight loss that might be undesirable in some patients treated for long periods of time."

"...the voracious appetite, with weight gain and euphoria, characteristic of other steroids, is not seen with administration of triamcinolone."

"Triamcinolone has been used for the management of a wide variety of clinical conditions usually considered amenable to systemic steroid therapy. These have included rheumatoid arthritis and other collagen diseases, allergic and dermatological disorders, certain leukemias and malignant lymphomas, the nephrotic syndrome, pulmonary emphysema and fibrosis, acute bursitis, rheumatic fever, and certain blood dyscrasias. Although clinical experience with the drug in some of the foregoing conditions is not extensive, the many similarities in action between triamcinolone and other potent glucocorticoids would indicate a usefulness for triamcinolone akin to that of other agents of this class."

"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"...the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism — rounding of the face, fat deposition, and hirsutism — are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

Aristocort®

Triamcinolone LEDERLE

Supplied: 1 mg. scored tablets (yellow)
2 mg. scored tablets (pink)
4 mg. scored tablets (white)

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

For every topical indication, a Burroughs Wellcome 'SPORIN'...



OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { LOTION: Plastic squeeze bottles of 20 cc.
NEW { POWDER: Shaker-top bottles of 10 Gm.



OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

pyelonephritis

"the most important concept is that it is a tubular disease" [1]

FURADANTIN®

brand of nitrofurantoin

a most important characteristic: effective at the tubular level



in each patient:
2 million reasons
for using
FURADANTIN first

In addition to simple glomerular filtration, FURADANTIN is actively excreted by the cells of the tubules. A significant and singular characteristic of FURADANTIN, it is but one reason why "the protracted administration of nitrofurantoin [FURADANTIN] to patients with ineradicable urinary tract infection, particularly chronic pyelonephritis without demonstrable obstruction, may usefully complement the medical management of this difficult problem."[2]

Available as Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Smith, I. M., and Lenyo, L.: Am. Practitioner 9:78, 1958. 2. Jawetz, E., et al.: A.M.A. Arch. Int. M. 100:549, 1957.

NITROFURANS—a *unique* class of antimicrobials—neither antibiotics nor sulfonamides

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CLINICAL BRIEFS FROM MODERN PRACTICE

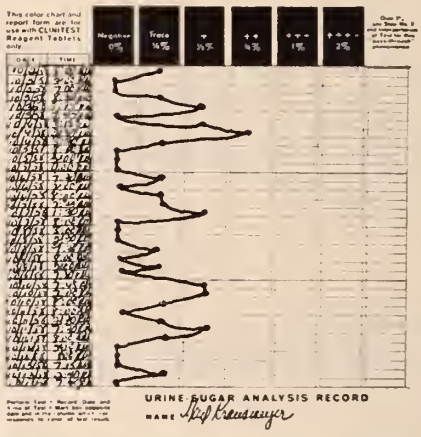
What differentiates "renal diabetes" (renal glycosuria) from diabetes mellitus?

Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

A "URINE-SUGAR PROFILE" FOR CLOSER CONTROL

The new CLINITEST Urine-Sugar Analysis Set contains an improved Analysis Record form that enables even closer control of the *moderate* and the *severe* diabetic. Daily urine-sugar readings may be connected to produce a graph—a day-to-day "profile" that reveals at a glance individual trends and degree of control.



color-calibrated

CLINITEST®

BRAND



60459

FOR EVEN BETTER CONTROL OF THE MODERATE AND THE SEVERE DIABETIC

the STANDARDIZED urine-sugar test for reliable quantitative estimations "...the most satisfactory method for home and office routine testing."*

*GP 16:121 (August) 1957

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada



when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1,2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

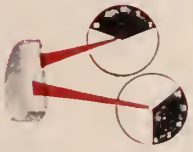
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4,5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6,7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Labricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

Triaminic®

TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.



Each TRIAMINIC timed-release tablet provides:
Phenylpropanolamine HCl.....50 mg.
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References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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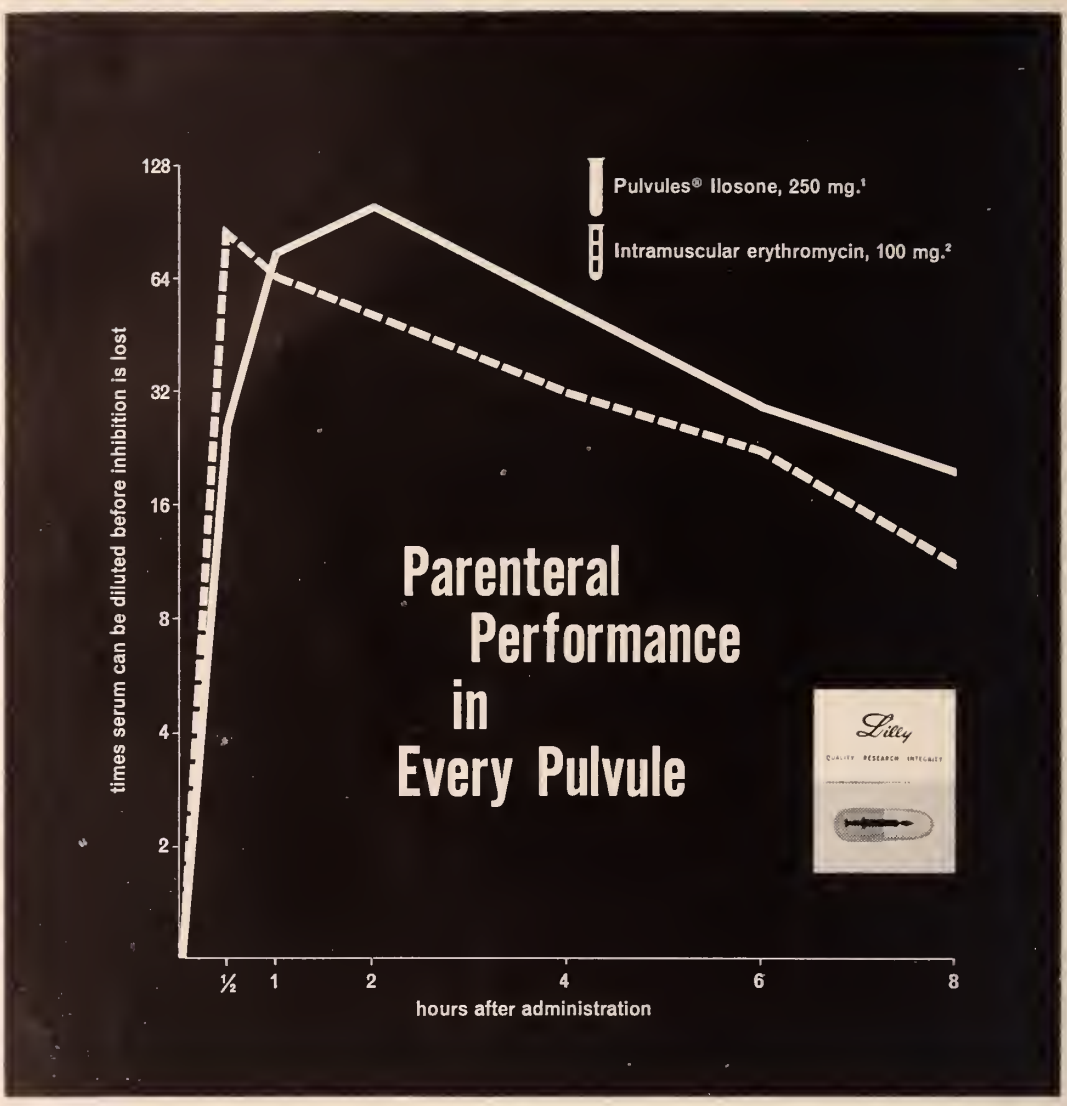
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1. Antibiotic Med. & Clin. Therapy, *5*:609, 1958.
2. Data from Antibiotics Annual, p. 269. 1954-1955.

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THE JOURNAL
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Editorials • • •

Meet Clyde Bowers



Many observers of the medical scene deplore the fact that physicians today are no longer interested in civic affairs as they were a century ago. It has been noted that in the old days the physician was not only concerned with his narrow, professional activities, but he also took part in the public affairs. Too many doctors today seem to tread the narrow path between office, home and hospital, and apparently look neither to the right nor to the left to see what is going on in their community.

This indictment can never be drawn against our new president, Dr. F. Clyde Bowers. He has served as Mayor of Mendham and chairman of the Planning Board of that community. He has been active in the work of the Mendham Youth Center, and treasurer of their Little League Baseball. He has been physician to the school board, to the Boy Scouts of America, and to the First Aid Squad. Dr. Bowers somehow manages to find time, as do

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all really busy men, for his civic responsibilities as well as for his professional duties.

Dr. Bowers was born in Phillipsburg, New Jersey in 1908, and was graduated in 1929 with a Bachelor's Degree from Lafayette College.He entered medical training at Temple University Medical School in Philadelphia and received his M.D. degree in 1933. He then came to intern at the Memorial Hospital and liked Morris County well enough to stay there and make it his home and his field of major activity.

He is married to the former Sara Taylor of Phillipsburg and they have two children. Since 1934 Dr. Bowers has been in general practice in Mendham. He has served as president of the Morris County Medical Society and chairman of the Medical Practice Committee of The Medical Society of New Jersey. He has had a tour of duty as councilor of the First Judicial District.

Since 1953 he has been president and chief of the medical staff of the Morristown Memorial Hospital, and chief of the Department of Internal Medicine at that hospital. During Word War II has was examiner to the Selective Service Board in Morris County. He is active in the affairs of the Academy of Medicine of New Jersey and the New York Academy of Sciences.

Dr. Bowers likes to think of himself as a small-town doctor. He brings to us all the warmth and neighborliness of the small-town resident; but in his professional and civic activities he is in the big leagues.

Pharmaceuticals of 1958

In February issue of Lippincott's sprightly *Medical Science,* there is a "New Products Parade" for 1958. It appears that in 1958, some 370 new pharmaceutical preparations (not just new dosage or package forms) were made available. This is about one a day, and when you come to think of it, it is an astonishing figure. Day in and day out, Sundays and holidays included, each day one brand new product! The year before there were 400 new products, so 1958 represented either a downturn in productivity or an agonizing re-appraisal. Two-thirds of the new products were multiple-ingredient preparations.

What was at the head of the parade, do you think? Antibiotics, vitamins, tranquilizers, or corticosteroids? Wrong. The number one spot went to skin preparations: unguents for itching, acne and other skin diseases. Perhaps human vanity is the strongest motivation for medical care. Or perhaps pharmaceutical manufacturers just like to make new ointments. Blending is an ancient and enchanting art. Results in dermatology are usually visible. Whatever the cause, 34 of the 370 new products—just about 10 per cent—were dermatologic preparations.

Products for the treatment of the common cold finished number two in this pharmacologic steeplechase. There were 20 of them—or, if the 13 brand new cough mixtures be included —33 new preparations in the upper respiratory field. Antibiotics finished next with 19 new ones. And then, in varying order: antihistaminics, corticosteroids, hypotensives, and, of course, tranquilizers. Apparently there is a traffic jam on the road to Milltown now, since in 1958 only six new tranquilizers were offered. Has the Tranquilizer-of-the-Month club been dissolved?

The first half of the twentieth century has been a fruitful age in pharmaceuticals. How pathetic now the little black bag of 50 years ago with its valerian, gelsemium, Fowler's solution and nux vomica. And how hopeful the horizon for the next quarter-century. Heart disease, malignancy, the psychoses, and hardened arteries. Which will be the theatre of the next pharmaceutical break-through?

The Servant of Medicine

The woods are full of people who would like to make over (or maybe, take over) the practice of medicine. Here and there, captains of industry or of labor are buying and building hospitals, setting up "closed panels" of doctors working on salary, and offering their group services through various local prepayment schemes. Trade unions in some large cities are organizing health centers, to provide an ever widening area of prepaid medical services through salaried physicians.

These plans represent a departure from medicine's traditional principles of free choice of physician for the patient and fee-for-service payment for the physician.

The one plan which adheres to the traditional physician-patient freedom is Blue Shield. This leaves the patient completely free to choose his own physician. It pays his doctor on a fee for service basis. It is adaptable both to the traditional mode of solo practice and to the new modes of group practice. It doesn't try to put medicine into a new mold—but it serves medicine under whatever pattern the doctor chooses to evolve.

Blue Shield bases its experience on the needs of the entire community. Thus it seeks to help our profession meet its overall responsibility to all the people—not just to those groups that are most powerfully organized or most favored as insurance "risks."

Blue Shield is the servant—not the master —of medicine.

Guest Editorial: Television Medicine

The practice of unlicensed medicine is booming on television. With "the take" running into millions and an unlimited sucker list, patent patter with illustrated results is hitting an all-time high.

Time was, when an evening before the home screen was a relaxing moment. Now the average viewer may well turn into an insomnic, headache-racked, gas-filled hypochondriac. Complete with proper settings, beautiful models and gruesome illustrations, medical hucksters are having an all-time visual field day.

Subjects usually discussed in the consultation room are aired with barroom candor. Indeed, why see your doctor when the implication of medical advertisers is that he has already heartily endorsed the product? "Approved by doctors everywhere," or "endorsed by leading hospitals" are oft-repeated phrases.

With a twist of the dial, advice on pimples, piles, bosoms and bottoms is given with dispatch and efficiency. Instantaneous relief from prescription-free drugs is graphically mirrored in the faces and forms of models whose quick changeability would shame a chameleon. In each case the medical profession, which by ethics and tradition may use no form of advertising, is a silent and unwitting partner.

Recently, I watched some television advice on laxatives. The model, a beautiful young girl, downed a foaming drink and shortly, by well defined implication, had her best evacuation in years. In that moment of youthful satisfaction, one could practically hear the final and triumphant vibration of the plumbing. The product was, of course, widely "prescribed by doctors."

Thrilling as it is for our profession to participate in such soul-shaking events, the thought occurs to me that doctors are being used, bilked, and horn-swoggled, for we are indelibly linked with the pain-free, burp-free vistas of the television medical man.

Barnum's cogent observation on humans would seem to apply equally to the public and to the followers of Hippocrates.

—ROBERT B. MARIN, M.D.

Original Articles • • •

David Biber, M.D.

Union

Treatment of Pulmonary Tuberculosis in Private Practice

The great white plague which once was the captain of the men of death, has now been harnessed, if not conquered. Under certain conditions, tuberculosis can be treated at home. But the doctor must know that he is assuming a ceaseless and serious responsibility.

This article describes some of the practical aspects of non-institutional treatment of pulmonary tuberculosis. It is based upon experience with over one hundred patients treated since the introduction of antimicrobial therapy. Most of these patients had no institutional care. The others had varying, but usually short periods, in sanatoria.

When a decision to treat a patient is made, the physician must be prepared for about two years of considerable responsibility. He cannot give the patient a prescription for some tablets and forget about him for weeks or months at a time. The patient must understand that he is to have a minimum of two years of treatment during which time he must expect to remain under close observation.

The decision as to whether a patient should have home or institutional care depends a good deal upon his personality, the status of his disease and his home conditions. Some of these points are discussed below.

PRELIMINARY OBSERVATION

Unless the situation is such that therapy must be instituted immediately it is wise to observe the patient first for about one month. This initial period gives the physician an opportunity to get some idea of the natural history of the disease as it occurs in this particular patient. Sometimes a preliminary period of observation may actually rule out the diagnosis of tuberculosis.

Case 1: A 31-year old woman had cough, expectoration and fever of two months' duration. X-ray showed right upper lobe infiltrations. These cleared after one week of penicillin treatment. Now, six years later, the x-ray is still clear.

If x-ray is the only evidence of tuberculosis a preliminary observation period could be used to obtain sputum specimens. I try to get two positive specimens. If direct smears are negative, cultures should be made. If the patient produces no sputum, cultures should be taken of gastric contents aspirated immediately upon awakening in the morning.

Sputum specimens are taken periodically during treatment. A good method is to take four daily consecutive specimens every month. The sputum should not be considered negative unless it becomes negative and remains negative. For example, if one positive specimen is recorded after four months of many negative specimens, the patient must be considered as having a positive sputum.

REST

Rest has always been an important part of the treatment of tuberculosis. Until fairly recently it was considered to be essential for adequate treatment. Absolute bed rest for periods of from 6 to 12 months has been used for all types of lesions, whether minimal or far advanced. However, many physicians feel that with the drugs now available strict, prolonged bed rest is no longer essential. It is too soon to say what amount of rest will ultimately prove to be best for any group of patients. I urge patients to take as much rest as their temperament and economic situation will allow.

Case 2: A 58-year old brewery worker who had a left upper lobe lesion with positive sputum refused to accept bed rest. He was treated with streptomycin for eight months. After six weeks of treatment, sputum became negative and remained so. He worked until his retirement seven years later at which time his sputum was still negative, his general condition was good, and his x-ray showed no evidence of active disease.

This was the first patient with active tuberculosis whom I treated on an ambulatory basis. He had no period of rest at all. However, I still urge a preliminary period of rest.

CONTAGIOUSNESS

If patients with active tuberculosis are to be treated at home the environment must be considered carefully from the standpoint of possible spread of the disease. The patient must be informed in plain language that he has a disease which he can transmit to those around him. Every member of the household must have an x-ray of the chest. There are some situations where home treatment cannot be considered. For example, the presence of an infant in the household or of other young children makes such treatment undesirable. Promises to remove children from the environment or to keep the patient isolated in his own room should be looked upon skeptically even if circumstances appear to be ideal. The physician should make at least one home visit to see for himself.

In many cases there is a prompt response to treatment so that the sputum becomes negative within a few weeks and improvement in the x-ray picture becomes apparent. When this occurs the physician might feel a little more secure about the problem of contagion; but it is well not to relax vigilance for several months.

How contagious is tuberculosis? The answer is not simple. For example, I saw one individual with a small lesion picked up in an x-ray survey whose eight siblings had all died of pulmonary tuberculosis. Such a situation, regardless of the question of host susceptability and hereditary effects, certainly indicates a high degree of contagiousness.

On the other hand I have seen many instances where one member of a family had tuberculosis which must have been active for about a year with no evidence of tuberculosis in other members of the household. In these individuals I have been unable to answer the two well known important questions: "From whom did he get it?" and "to whom did he give it?" Such instances of isolated tuberculosis have been common in my experience. By "isolated" I mean situations where all relatives of the patient (as far as is known) have no x-ray evidence of active or healed tuberculosis. However, despite this curious problem in epidemiology, tuberculosis in practical clinical and public health work must be considered to be a contagious disease.

HEMOPTYSIS

The patient who has blood spitting as his first symptom of pulmonary tuberculosis is often fortunate, because this dramatic symptom causes him to seek medical attention promptly. If he had not had hemoptysis the disease might have continued an insidious course, symptomless until far advanced. In this series there were 16 patients who had blood spitting as the first recognized symptom. All 16 have done well.

Hemoptysis does not indicate advanced disease, for it may occur at any stage. Neither does it necessarily indicate active disease. I

have seen many individuals spit blood twenty or more years after a period of active tuberculosis. Close study of most of these has failed to reveal evidence of renewed activity.

Of course, in such circumstances other diseases such as cancer must be considered, as it was in eight patients in this group who were forty-four years of age and older. Each of these were followed closely for several years. Six of them were bronchoscoped. At this time, two to fifteen years after the hemorrhage, none has shown any evidence of malignancy. Active tuberculosis was present in one of the eight, a woman of forty-six.

The treatment of hemoptysis starts with putting the patient to bed at least until the sputum is clear of blood. Many phthisiologists place ice bags on the chest and give the patient small bits of cracked ice to swallow. These measures do not stop the bleeding, but they do give the patient something to do, often counteracting his feeling of helplessness. Codeine is useful to suppress the cough.

A search should be made for a coagulation defect. I have never found one in hemoptysis due to tuberculosis.

DRUG THERAPY

MANY chemicals and antibiotics are now available for treating tuberculosis. Those considered to be most effective include streptomycin, isoniazide, paraminosalicylic acid, Viomycin®, cycloserine and pyrazinoic acid amide. Terramycin® is also said to have some anti-tuberculosis activity, but I have had no experience with it. I am using pyrazinoic acid amide infrequently because of its toxicity to the liver.

Streptomycin is usually given in doses of 1 Gram intramuscularly every third day or twice a week. I use it twice a week. Toxic effects include dizziness and loss of balance. Dihydrostreptomycin has the same anti-tuberculosis effect, but when it becomes toxic it affects hearing rather than balance. I have not seen many toxic effects from either of the streptomycins. There was one 42-year old woman, who after three months of streptomycin given at a dose of 1 Gram twice a week developed a loss of balance severe enough to interfere with walking. The drug was discontinued and her sense of balance returned to normal gradually over the next four weeks. Some patients report a headache several hours after the injection and some report peripheral paresthesias. These symptoms are not constant and seldom require discontinuing the drug. For the past few years it has been advocated that streptomycin and dihydrostreptomycin be given, 500 milligrams at each dose with the idea of diminishing the number of instances of and the severity of toxic reactions. I have seen fewer reactions since using this mixture.

Isoniazide is generally considered to be the most effective of all anti-tuberculosis drugs. It is generally given in doses of 300 to 400 milligrams a day. According to most writers about 5 per cent of patients given isoniazide will develop hyperreflexia or paresthesia. With one exception I have not had to consider isoniazide toxicity seriously.

Case 3: After two weeks of antituberculosis therapy a 59-year old man was found to have an unremitting fever, paresthesias of hands and feet, and a deteriorating disposition. Suspicion of a drug reaction was confirmed by elimination tests. Isoniazide was found to be the offender. Treatment was continued using streptomycin and PAS. Oral desensitization to isoniazide was carried out by starting with one-half milligram per day and gradually increasing the dose until 400 milligrams per day were tolerated. Pyridoxine was added in a dose of one hundred milligrams three times a day.

Anti-tuberculosis drugs should not be given singly. It has been observed both experimentally and clinically that the development of drug resistance by the tubercle bacillus is delayed if two drugs are given simultaneously.

The duration of treatment is important. One year of drug therapy must be considered the minimum but, if it is possible, treatment should be continued for two years. In most cases I start with streptomycin, isoniazide, and PAS. At the end of one year streptomycin is discontinued and another antibiotic substituted. Recently I have been using cycloserine for this purpose. Isoniazide is given continuously throughout the entire course of treatment.

Some patients develop gastro-intestinal symptoms, such as nausea, vomiting and diar-

rhea from PAS. When this happens I reduce the dose of the drug or eliminate it entirely for a few days. When the symptoms have cleared the drug is resumed starting with a low dose and gradually increasing it until a dose of 10 to 12 Grams per day is reached. Most patients will tolerate the drug following such a routine. Occasionally a patient can tolerate no more than 8 Grams per day, so he is left on this dose level. PAS is goiterogenic. I have seen one case of thyroid enlargement.

Case 4: A 47-year old man in the sixth month of treatment was found to have a soft and enlarged thyroid with swelling of the face and neck. There were no signs of thyroid toxicity or insufficiency. PAS was discontinued and the swelling subsided within two weeks.

Cycloserine is a more recent drug. It is effective. Convulsions occur as a serious side effect, but are infrequent when it is given in a dose of 250 milligrams every twelve hours. Some of my patients have complained of restlessness of the legs and paresthesias. The toxic effects of cycloserine are similar to but more severe than those of isoniazide.

Viomycin® is useful as an extra secondary drug. Its usefulness is limited by its nephrotoxicity but given in doses of a Gram twice a week it is comparatively safe. The urine should be checked frequently.

Pyrazinoic acid amide may be useful where a prompt effect is needed as in very severe, acute disease. It produces liver damage. Another disadvantage is the fact that the organisms rapidly become resistant to it.

Cortisone and its synthetic chemical relatives have been known to activate a latent tuberculous lesion, the existence of which neither patient nor physician were aware. On the other hand these drugs are occasionally useful in the treatment of an acutely ill, toxic, tuberculosis patient.

Case 5: A 38-year old woman had bilateral active disease which, according to her history, had had an insidious onset about six months previously. She was weak, toxic and febrile, and had chills and sweats. Streptomycin, PAS and isoniazide were started at once and pyrazinoic acid amide was added in an attempt to get a prompt effect. Thirty milligrams of metacortone were given daily for eight weeks. Pyrazinoic acid amide was discontinued after twelve weeks. Now, six months after therapy was started, cough and expectoration are still present but much diminished. The x-ray shows some clearing and the sputum has been negative for two months. It is not possible to say that this woman will go on to complete healing and rehabilitation, but I feel that without the vigorous treatment described she would now be in a hopeless condition.

Pyrazinoic acid amide was administered to this woman because of the severity and acuteness of the disease. Metacortone was added because of the severe toxicity. It was helpful in producing symptomatic improvement. Corticoids have a place in the treatment of tuberculosis, but they should not be used for more than a limited period of time and never without the simultaneous administration of antituberculosis drugs.

THE MINIMAL LESION

THIS is a difficult problem. Usually the lesion is discovered in an x-ray survey or by casual x-ray of an individual who has no symptoms. The physician is then faced with a patient who appears to be in good health and whose x-ray shows a small infiltration. There may be no cough and no expectoration and gastric washings may yield no tubercle bacilli; yet the tuberculin test is positive. The only sensible course is to treat the patient for tuberculosis for a minimum of one year.

These minimal lesions are treacherous. I have never been able to determine from the x-ray appearance which will resolve quickly and which, if untreated, will develop into far-advanced disease. As with most other types of tuberculosis I usually prefer to observe these for one month before treatment is started.

Sometimes a minimal lesion is discovered in an individual who produces sputum containing acid-fast bacilli. These, of course, present no diagnostic problem.

Case 6: A physician did a routine chest plate on a 26-year old woman. He found a small infiltration beneath the right clavicle. The tuberculin skin test was positive. There were no symptoms and the gastric washings were negative for tubercle bacilli on culture. A month later, a second x-ray showed no change. Antimicrobial therapy

was started and at the end of another month, the third x-ray showed complete resolution of the lesion. The referring physician doubted that a tuberculous lesion could resolve so quickly, but it was decided to continue treatment for at least one year.

Case 7: This was a woman of 39 with a lesion similar in x-ray appearance to the one described above. The sputum was negative for acid-fast bacilli. She was treated for six months with no change in the lesion. At this time a small nodule was discovered on the thyroid gland and by means of biopsy, a diagnosis of carcinoma of the thyroid was made. She had a complete thyroidectomy with neck dissection. It was decided to discontinue antituberculosis therapy because it was believed that the original infiltration represented a metastatic lesion. One year later she was found to have far advanced pulmonary disease. Acid-fast bacilli were easily recovered from her sputum.

In this patient abandonment of antituberculosis therapy at the end of six months seemed justified. On the other hand it might have been wise to apply the general rule of maintaining drug therapy for a minimum of one year, once it had been started.

INDICATIONS FOR SURGERY

SURGICAL resection of a tuberculous lung or sub-division of a lung became practical when antibiotics and chemotherapy were introduced for the treatment of tuberculosis. Although the general trend for the past few years has been for less surgery, there are many individuals who do not respond satisfactorily to medical treatment, and whose lesions are sufficiently localized to make surgical resection practical. If by means of antimicrobial therapy a patient is brought to a point where his sputum is persistently negative, and his x-rays show no evidence of cavitation, then surgery is *not* indicated. At the other extreme if after several months of antimicrobial treatment a patient's sputum still shows tubercle bacilli then that patient is a tentative candidate for resection. Such a patient must be surveyed carefully with particular attention to the status of his tuberculosis. For example, if there are many lesions visible on the x-ray, one must be certain one knows which lesion is responsible for the positive sputum before surgery is recommended.

Case 8: A 25-year old woman had a spherical, calcified left upper lobe lesion. Her sputum was positive and remained positive after five months of antimicrobial therapy. Surgical treatment was advised and she had a lobectomy. The sputum became negative at once. Now, eight years after the operation, her x-ray is clear and there has been no clinical or microbial relapse.

TUBERCULOSIS IN CHILDREN

TUBERCULOSIS is easily detected in children by means of a tuberculin test. When the physician finds a positive skin test in a young child he should seriously consider the possibility that active tuberculosis is present or imminent.

In past years the clinician paid little attention to the child who had a positive tuberculin test if there were few or no signs or symptoms. It was felt important to find the source of the infection in the child's environment and to separate him from that source. Direct treatment of the child by preventorium care was considered to be effective only because it separated him from the source of infection.

It is now advocated that intensive antituberculosis drug therapy be given to all positive skin reactors under two years of age, even though they have no signs or symptoms. This is a reasonable attitude. It has long been known that a small but definite number of these infants will develop advancing disease and meningitis.

With these facts in mind I have been treating all children under 3 who react to tuberculin, even though there are no symptoms and physical examination and x-ray are negative. I give isoniazide, the daily dose being 10 milligrams per kilogram of body weight. Children tolerate it well.

Here an elementary and important point must be emphasized. Whenever a child is found to have a tuberculin reaction, every adult in the child's environment must be examined and have an x-ray of the chest. All possible adult contacts should be included, not excepting grandma and grandpa and relatives who visit frequently. Other children in the household need be x-rayed only if they have a positive tuberculin reaction.

Case 9: Several years ago, before streptomycin had become available, I was called to see a child 18 months of age. A pediatrician had diagnosed tuberculosis meningitis. This was verified bacteriologically.

Inquiry revealed that at one year of age a routine Patch test was found to be positive. X-ray of the chest was negative. The physician who was seeing the child at that time told the parents that nothing more need be done because "most everybody has a positive tuberculin test anyway."

I explained to the parents of the infant that everyone in the household should be x-rayed and they readily agreed. The child's grandfather was found to have cavitary disease, and his sputum was positive.

In this case, a physician who was alert enough to do a routine tuberculin test made an erroneous interpretation. He should have made a diligent search for the source of the infection in order to remove it from the household. Today we can go a step farther. We treat the infant with a positive tuberculin test even though he has no symptoms.

DEATHS

THERE would be few deaths from tuberculosis if early case finding and prompt treatment were universally applied.

There were four deaths in this series. Two of these patients came to me in a hopeless, far-advanced state. A third died following a laparotomy for a non-tuberculosis condition.

The fourth patient had had some dizziness during streptomycin therapy about two years before her death. There appeared to be good response to treatment which included a lobectomy. One year later while away on a trip she was given one injection of a streptomycin and penicillin mixture for a respiratory infection with a return of the dizziness in a severe and almost intractable form. She seemed to recover from this illness, but went into a decline, developing ascites, edema of the feet and a large liver. She died in liver failure several months later. Autopsy showed severe atrophy of the liver. It is possible that in this patient streptomycin was toxic to the liver.

LITERATURE

ARTICLES about tuberculosis are published frequently in the general medical journals such as *Archives of Internal Medicine* and *Annals of Internal Medicine*.

Diseases of the Chest and *American Review of Tuberculosis and Pulmonary Diseases* have papers on tuberculosis in every issue.

One of the best fundamental books on tuberculosis is Arnold Rich's *The Pathogenesis of Tuberculosis*.* It is a detailed and thorough discussion based on laboratory, clinical and epidemiologic data. It can be opened anywhere and found interesting.

*Published by Charles C Thomas Springfield, Illinois.

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Tetanus: A Current Appraisal

Widespread immunization programs have made us feel too secure about tetanus. Yet this dreadful disease is still with us. Some ten tetanus deaths a year are reported in New Jersey alone. Here is a useful little monograph on how to treat tetanus.

Every year, there are about 150 cases of clinical tetanus in the United States, most of them fatal. In New Jersey, some 8 to 10 fatal cases have been reported annually.[15] The authors recently experienced the most unusual circumstances of having two concurrent cases hospitalized at Overlook Hospital, Summit, New Jersey. Our purpose is to report these successfully treated cases, to review the management of this most challenging disease, and to share some of the experiences we have gained from these cases.

CASE ONE

A 72-year old woman was admitted to Overlook Hospital with dysphagia which had started 3 days earlier. At that time, there was no observable obstruction to the swallowing of barium. She complained of suboccipital headache. Oral temperature was 100.2. Her dysphagia progressed, and on admission was almost complete. The throat was less inflamed, and considerable rigidity of the strap muscles of the neck was present, but flexion could be accomplished.

Esophogram at this time showed almost complete obstruction. On esophagoscopy, the obstructing process seen at the entrance of the esophagus was compatible with neoplasm. Biopsy revealed only a necrotic inflammatory mucosa. A Levine tube was passed and a Waring blended high protein diet and fluids were given.

Lumbar puncture, hemogram, chest and cervical spine x-rays were all normal.

Six days later, muscular rigidity became more generalized with the appearance of risus sardonicus, opisthotonos and jaw occlusion. An episode of laryngospasm with cyanosis necessitated emergency tracheotomy. Under thiopental anesthesia, there was a remarkable relaxation of the generalized tetanus, and an esophagoscope was passed, which encountered no obstruction. In retrospect, the original obstruction was probably due to localized cricopharyngeus tetanus.

Treatment consisted of oxygen with a mucolytic aerosol* in a croup tent, and later a tracheotomy collar, tetanus antitoxin in two intramuscular doses of 60,000 units each, and 6 million units of penicillin daily. Sedation was given in the form of intramuscular amobarbital sodium and phenobarbital *via* Levine tube, 100 to 200 milligrams every 6 hours or enough to maintain narcosis without respiratory depression. Methocarbamol† *via* Levine tube in doses up to 16 Grams daily was well tolerated and contributed considerably to the improvement which ensued. Intensive nursing care with frequent turning and tracheotomy aspiration were of vital importance. Urinary bladder catheter drainage was essential because of incontinence. This helped in obtaining measured urinary outputs. Together with estimated insensible water loss, this determined daily fluid intake. Ace® elastic band-

†We used the brand of methocarbamol tradenamed Robaxin® by the A. H. Robins Co.

*We used the Winthrop-Stearns preparation tradenamed as Mevaire®

ages were maintained on the legs as a phlebitis prophylaxis. Chloramphenicol® was substituted for penicillin when a penicillin resistant coagulase positive hemolytic staphylococcus aureus was cultured from the tracheotomy. Lung fields remained clear and there were no other signs of staphylococcal infection.

The generalized tetanus receded promptly after the above program was instituted, but the localized lockjaw and neck spasm persisted for three weeks before subsiding. The Levine tube and tracheotomy were then removed successfully and the tracheotomy wound promptly healed. She was discharged 30 days after admission, following her first dose of tetanus toxoid. There had been no prior active tetanus immunization, and no specific wound history or findings associated with this illness. However, there was exposure to horse manure fertilizer in her garden, and the history of some thorn pricks in the month prior to onset.

CASE TWO

A 59-year old man was admitted to Overlook Hospital, 8 days after he had had a contusion and laceration of his third left finger, caused by a rusty iron bar. He entered the hospital because of jaw tightness. Neurologic consultation on admission did not support the diagnosis of tetanus because of the lack of other clinical signs.

Two days later, he had progressed to rigidity of his neck muscles, risus sardonicus, opisthotonos, masseter spasm and exaggerated deep tendon reflexes. The diagnosis of tetanus was then made on these clinical findings. In the next five days, a total of 215,000 units of tetanus anti-toxin was administered by intramuscular and intravenous routes. Tracheotomy was done on the sixth day after admission. Then he was given methocarbamol† in doses up to 12 Grams per day by mouth and 400 milligrams per day intravenously. Prednisone was started in doses of 30 milligrams per day, but the dose was gradually diminished and finally stopped when the patient developed thrombophlebitis in the leg.

Phenobarbital was given in doses of 200 to 800 milligrams per day between June 13 and June 20. Phenergan® (Wyeth) was given, 75 milligrams per day for 5 days. We also used antibiotics. One dose (1 c.c.) of curare was also given. Oxygen *via* tent, with mucolytic aerosol inhalations* were administered for 7 days. A special liquid Sustagen® diet preparation was given by Levine tube during the acute illness. Electrolyte balance was maintained with parenteral fluids during the acute phase. One blood transfusion of 500 cubic centimeters was administered on the 19th day after admission.

During the course of his convalescence two major complications developed. One was thrombophlebitis in the right leg, which spread to the left leg. This problem persisted in this acute stage until shortly before the patient's discharge. Six weeks following hospitalization, he still has to wear elastic stockings because of the swelling of the extremities. The thrombophlebitis was treated with a coumarin product, with trypsin (we used the National Drug Company's brand tradenamed Parenzyme®), with a streptokinase—streptodornase combination tradenamed by Lederle as Varidase®, and with antibiotics as well as with leg binding.

His second complication was a lung infection which, a month after admission was disclosed by x-ray as a soft infiltration in the right mid-lung field. Lung x-rays 2 weeks later showed complete clearing of the process. The patient remained febrile for another 3 weeks, largely because of these complications.

The clonic spasms of various muscle groups gradually subsided, starting 6 weeks after admission. The jaw spasm and laryngospasm subsided after an additional week. The tracheotomy tube was removed later, and the wound healed spontaneously and promptly. When the patient left the hospital, 8 weeks after admission, there was no clinical sign of tetanus remaining. He received 0.5 cubic centimeters of tetanus toxoid fluid at the time of discharge and further immunization with toxoid was contemplated.

Tetanus has been recognized since antiquity. As it often followed war wounds, it was the scourge of the battlefield. Not until 1889 when *Clostridium tetani* was isolated by Kitasato, was there any knowledge of the nature of the disease. In 1890 the first successful immunization was done by Behring and Kitasato. In 1925 tetanus toxoid was discovered by Ramon.[1]

Clostridium tetani is a ubiquitous germ, found chiefly in the soil but also in the gastrointestinal tracts of man and a wide variety of animals. It has even been recovered from the floors of operating rooms. This organism cannot be isolated from most wounds of tetanus patients; yet it has been recovered from the wounds of people who did not have tetanus. An attempt to isolate *Clostridium tetani* from a wound in order to establish a diagnosis, is time-consuming and impractical. The diagnosis has to be made on clinical grounds.[2]

PATHOGENESIS

For *Clostridium tetani* to thrive in a wound, devitalized tissue must be present. Tetanus has been associated with highway trauma and other injuries usually outdoors; but it has also been known to follow hypodermic injections and smallpox vaccinations. In a significant proportion of cases, there is no history of a wound at all. A toxin is produced by *Clostridium te-*

tani. There is controversy[3] over whether the toxin is carried by the blood stream to the central nervous system (then spreading peripherally along the nerve trunks) or whether the toxin involves the peripheral nerves first.

Postmortem examination reveals no specific tetanus lesions other than those of secondary complications.

AGE

ANY age may become afflicted, but more than half the cases occur in the age group below 15. Tetanus neonatorum is a common problem in many parts of the world. Both of our reported cases were in older groups. As this is the group least likely to have been immunized, one may expect a shift in age incidence.

CLINICAL COURSE

THE incubation period lasts from 3 to 28 days, but in more than half the cases, it is less than 10 days. The severity of the disease varies inversely with the incubation period. Patients with an incubation period greater than 10 days, have a more favorable prognosis.

The first sign is usually a spasm of the jaw. The tetanus may remain localized for several days before other muscles become involved. Then in varying order, the following changes may ensue: dysphagia, irritability, extreme restlessness, stiffness and rigidity of the neck, opisthotonos, salivation, diaphoresis, increasingly exaggerated deep tendon reflexes, periodic convulsive seizures, rapid shallow respirations and laryngospasm, which may cause a sudden fatal termination.

Complications may be grouped into the following three categories:

1. *Respiratory*: Obstruction to the respiratory passages favor the development of atelectasis, pneumonitis, lung abscess, and so forth.

2. *Adverse reaction* to the medications used in the treatment of the tetanus; *e.g.*, serum sickness from antitoxin.

3. Those of any severe *debilitating illness* requiring prolonged immobilization; *e.g.*, thrombophlebitis.

Mortality varies from 14 to 60 per cent[4] and is inversely proportional to the availability of frequent and intensive medical and nursing attendance.[12]

THERAPY

THE goals of therapy may be summarized as follows: (A.) to neutralize the uncombined toxin. (B.) To eliminate foci of residual *Clostridium tetani* infection. (C.) To support the patient through this self-limited disease; maintain nutritions, fluid balance, and an adequate airway at all times.

Recovery is likely to be complete when it occurs.[5,6,7]

Tracheotomy should be done routinely as soon as the diagnosis is made. Some[8] feel that tracheotomy is not indicated in mild cases, as in patients having an incubation period greater than 10 days. However, since sudden laryngospasm is the usual cause of death, serious consideration should be given to early tracheotomy in all cases.

Nebulized detergents and *oxygen* are indicated. It is often advisable to use mucolytic aerosols such as Alevaire® (Winthrop-Stearns) to liquefy secretions and facilitate airway maintenance. Oxygen must be available because of the frequency of rapid shallow respirations and anoxic complications. Both the oxygen and the aerosols can be administered through a tracheotomy collar[14] which can be purchased, or improvised by using a plastic bottle into which holes are cut. These allow the collar to fit snugly over the tracheotomy and allow for entrance of a tube connected to the source of oxygen.

Nursing care is imperative for maintenance of absolute quiet, for frequent turning, tracheotomy aspiration, tube feeding, and constant surveillance for sudden laryngospasm or respiratory embarrassment.

Tetanus antitoxin is a matter of controversy here. By the time the symptoms appear, the

toxin is already fixed with the central nervous system tissue. All that further antitoxin will do is neutralize additional toxin emanating from the site of the necrotic tissue. One author [12] advised immediate intravenous injection of 200,000 units. Others recommend 60,000 to 100,000 units intra-muscularly in smaller doses. Still others question the advisability of giving the tetanus antitoxin at all.

Antibiotics should be used. Penicillin, which is bactericidal, will eliminate any residual tetanus organisms. More versatile antibiotics may also be used for the secondary infections that may arise.

Sedation is advised to keep the patient calm and relaxed—even asleep—during the acute stage. Care should be taken [9] not to suppress respirations. Phenobarbital may be given in appropriate doses. Amobarbital sodium (0.25 to 0.50 Grams in 10 per cent solution) intramuscularly every 4 to 6 hours may be advisable. Also, thiopental sodium, 0.2 per cent in daily doses of 0.5 to 2.5 Grams may be titrated intravenously [10] as needed to control convulsions.

Skeletal muscle relaxants are advisable. The three usual relaxants are curare, mephenesin and methocarbamol. Curare paralyzes motor end-plates and requires that the doctor have available mechanical ventilation facilities through a respirator. It is, furthermore, a seriously toxic drug. We used methocarbamol† under its Robins tradename of Robaxin®. This exerted a prolonged, selective depressant action on internuncial neurones. We found methocarbamol† so successful a drug, that we had no need for other muscle relaxants. It is available in 500 milligram tablets. These are pulverized and passed through Levine tubes. Methocarbamol† is also prepared in 400 milligram ampules for intravenous use. It seems to be safe to use it even though the urine may soon show a greenish color due to passage of a harmless excretory chromogen. Mephenesin in our hands seemed less effective than methocarbamol,† though its general physiologic effect is similar.

Maintenance of fluid and electrolytic balance must be thought of. During the early stages, especially when the patient is febrile, diaphoretic, and heavily narcotized, there may be danger of dehydration due to lack of voluntary fluid intake; and conversely, a hazard of pulmonary edema, if over-hydrated by too vigorous parenteral fluid administration. Fluid intake should be based on measured urinary output and insensible water losses. Blood electrolytes should be measured periodically and adjustments made accordingly.

Wound debridement should be done promptly to eliminate any further absorption of toxin, and to remove devitalized tissue on which *Clostridium* thrives.

Feeding will have to be by Levine tube or parenterally, depending on the severity of case. Gastrostomy is rarely necessary. We found the use of a natural high protein diet including vegetables, cereals, meats, milk and eggs, liquefied in a blender, to be most satisfactory and easily administered through a Levine tube. On this regimen, our first patient lost only one pound during her entire hospitalization, and did not have the diarrhea so often encountered with high protein powdered supplements.

PROPHYLAXIS

THE disease tetanus and the tetanus antitoxin will immunize the patient for only 4 weeks and second attacks of tetanus have been known to occur. Therefore, within the 4 week interval, immunization with tetanus toxoid should be instituted. For this purpose one may use tetanus toxoid fluid, 1 cubic centimeter, for 3 doses given every 2 to 3 weeks. A booster should be given in 6 to 12 months and then a booster of 1 cubic centimeter every 5 years thereafter. Instead of the fluid toxoid one may use the alum-precipitated toxoid. In that case give a half to one cubic centimeter for 2 doses at a 4 to 6 week interval. A booster is then given between 6 and 12 months later; and then a booster every 5 years. This prophylactic program [11] applies of course to all persons who wish to be protected against this disease.

Fortunately, most youngsters or veterans of the armed forces have already received basic immunization. However, many are remiss in

not obtaining booster doses at 4 to 5 year intervals. In addition, there is a large segment of our population who have never been actively immunized, especially in the older age groups. Here, more intensive programs along these lines should be instituted. Tetanus antitoxin administered at the time of injury may have little or no effect [11] on prevention of tetanus especially in the 1500 unit dose customarily used.[12] The high incidence of serum sickness afterwards would also favor a policy of more active immunization with toxoid rather than reliance on antitoxin. The fact that there are an average of ten deaths per year from tetanus in New Jersey shows that this is still a disease to be contended with.

SUMMARY

Two concurrently hospitalized and successfully treated cases of tetanus are reported. The problems of management of this most challenging disease are reviewed, and certain aspects which we found most helpful, are emphasized. The significant incidence and high mortality demands a more active immunization program.

ACKNOWLEDGMENT

The authors express grateful acknowledgment to the many who were involved in these cases—more especially Samuel W. Eason, M.D., Mildred T. Bohne, M.D., Robert E. Green, M.D., Charles E. Langgaard, M.D., and W. Franklin Keim, M.D.

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Shoe-Fitting Fluoroscopes

Shoe-fitting fluoroscopes have been indicted for their radiation hazard and have been outlawed in Pennsylvania, Vermont, Texas, New York, South Dakota and Montana. Dr. Jan Lieben, director of the Pennsylvania State Health Department's Division of Industrial Hygiene, cited two cases of radiation damage from the use of these machines, explaining that radiation injuries are slow to appear. —*The American Journal of Nursing*, June, 1958.

Murray Nussbaum, M.D.

Jersey City

Practical Aspects of Iron Metabolism*

Iron is not a glamorous element, and physicians seem little interested in iron metabolism. Yet, this element cannot be eliminated (except through hemorrhage) so that its accumulation may conspicuously affect metabolism. Seventy per cent of the iron prescribed by physicians is wasted.

Over 70 per cent of the iron prescribed by physicians is wasted. In most instances, the hematologic disorder for which the medication was prescribed remains unaltered. In a good number of cases, some harm is inflicted by the indiscriminate administration of iron. An understanding of the metabolism of iron, as it applies to hemopoiesis, is a necessary prerequisite to the management of red blood cell disorders.

The total amount of iron in the body is about 4 Grams, of which 2.5 Grams are in the red blood cell mass. Conveniently, this comes to about 1 milligram of iron per milliliter of red cells. An additional 1 to 1.5 Grams is in the form of storage iron in the liver, bone marrow and reticuloendothelial system. Approximately 3 milligrams is in the plasma at any one time. A comparatively small total quantity is present in the myoglobin mass and the cytochrome enzymes, and will not be considered in this discussion.

Iron metabolism must be considered from several physiologic aspects, including absorption, excretion, transport in the blood stream, storage, and incorporation into the red blood cell.

*Presented before the Section on Metabolism of The Medical Society of New Jersey at Atlantic City, May 21, 1958. This work is from the Seton Hall College of Medicine and Dentistry.

IRON EXCRETION

Iron excretion is almost completely absent.

Dubach, Moore and Callender [1] have determined the excretion of iron in the normal male

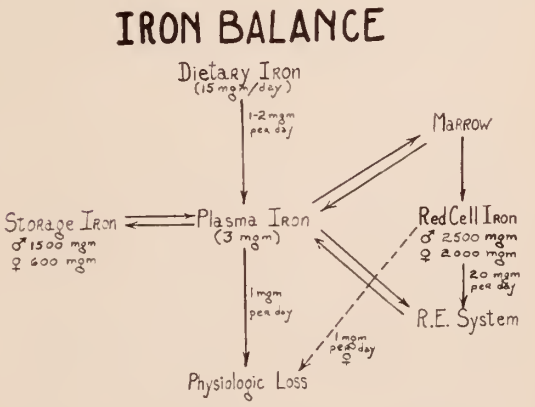


Figure 1. Normal iron balance in the adult. The total amount of iron in the body is about 4 Grams. Of this amount, 2 to 2.5 Grams are in the red blood cell mass as part of the hemoglobin molecule. An additional 1 to 1.5 Grams are in the stores. At any one time, there is a total of about 3 milligrams of iron in the plasma. A small amount of iron is lost daily in the mucosal sloughs. The female loses an additional amount *via* menstruation. This "Physiologic Loss" is replaced by iron absorbed from the diet. Approximately 20 to 25 milligrams of iron are liberated daily from the normal destruction of senescent red cells, and are used preferentially for the resynthesis of hemoglobin.

to range between 0.03 milligram to 1.5 milligrams per day, with an average loss of about 1.0 milligram per day. This loss occurs chiefly *via* the gastro-intestinal and genito-urinary mucosal slough, and is easily replaced by iron absorbed from the gastro-intestinal tract, amounting to about 10 per cent of the total iron in the diet. The average adult female loses an additional 17 to 40 milligrams of iron per menstrual cycle for an average of an additional milligram per day. During pregnancy, approximately 270 milligrams are therefore saved because of amenorrhea; but an estimated 720 milligrams are lost to the fetus, placenta and during hemorrhage. Thus, to replace physiologic loss, the pregnant female requires about 4 milligrams of iron daily compared to the 2 milligrams needed by the nonpregnant female and one milligram by the normal male. In the female, this excess excretion of iron via menstruation and pregnancy may assume an important role in the etiology of iron deficiency. In the male, excretion is practically nil. Once iron is introduced into the body, there is little chance for it to be lost except by hemorrhage.

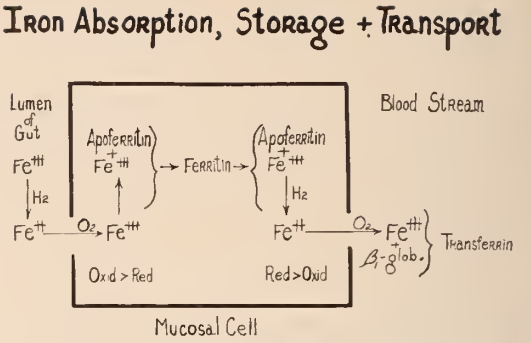


Figure 2. Illustration of iron absorption, storage and transport. Ferrous salts in the lumen of the gut stimulate the production of "apoferritin" in the mucosal cell, which combines with ferrous iron to form ferritin, after the iron crosses the mucosal membrane in the ferrous state. Iron is temporarily stored in the cell as part of the ferritin molecule. If the level of the serum iron drops because of iron deficiency, ferritin is again reduced to apoferritin and ferrous iron. Iron then crosses the vascular side of the cell membrane, is oxidized to the trivalent state and is bound to a beta-1-globulin in the plasma "Transferrin" and is then transported to the sites of utilization and storage. It is proposed that oxidation is greater than reduction at the luminal side of the cell, and reduction greater than oxidation at the vascular side.

IRON ABSORPTION

SINCE there is no excretory organ for iron, the regulation of the amount present in the body appears to be an exclusive function of the amount absorbed. From this, one may infer that it is only the gastro-intestinal tract which can accept or reject iron, depending on the need for it. The concept of "mucosal block" was elaborated in 1943.[2] This proposed that the amount of iron absorbed depends on the saturation of the mucosal cells with iron. Granick[3] further elaborated this concept as follows: the presence of ferrous salts in the intestinal lumen stimulates the formation of a protein "apoferritin" within the mucosal cell. The divalent iron molecule crosses the cell membrane, and once within the cell, is oxidized to the trivalent state, combines with apoferritin, and is stored temporarily in the mucosal cell as part of the ferritin molecule. Ferritin in turn, is in equilibrium with iron in the plasma. With iron deficiency, the level of plasma iron falls, ferritin is again reduced to apoferritin and ferrous iron; the iron crosses the vascular side of the cell membrane into the blood stream in an attempt to restore the plasma level. If tissue stores are normal, the plasma iron level is maintained, absorption into the cell continues until it is completely saturated with ferritin, and then stops. It would appear that an oxidation-reduction potential exists within the cell. Oxidation being greater at the luminal end of the cell while reduction is greater at the vascular side.

However, certain facts are inconsistent with this concept. Iron is absorbed in the face of tissue saturation[4] and in the face of prolonged ingestion of iron rich diets.[5] There are, therefore, additional factors concerned with iron absorption besides "mucosal saturation and block." These may be considered as local (*i.e.* —they come into play at the site of absorption) and internal factors.

LOCAL FACTORS

THERE is general agreement that iron absorption in man takes place only when iron is in the *ferrous* form. The composition of the diet is therefore of importance in determining the availability of iron for absorption. Since most food iron is in the *ferric* state, the administration of reducing substances such as ascorbic acid in doses of 500 to 1000 milligrams with meals will double the amount of food iron absorbed.[6] Ferrous salts given alone are more readily absorbed than food iron, but this increase is unchanged by adding reducing substances or cobalt. The efficiency of gastric hydrochloric acid as a reducing substance for absorption is debatable, as iron absorption increases in deficiency, despite achlorhydria.[7] Iron absorption occurs all along the gastrointestinal tract but is best just below the pylorus, and decreases beyond this point. This is, perhaps, due to the increasing alkalinity of pancreatic secretions, since in rats and mice, pancreatic damage will allow for increased iron absorption.[8] The total amount of iron presented to the intestinal mucosa is also of importance.[9] Although the proportion of the administered dose absorbed is decreased, the absolute amount may be increased,[10] especially when administered over prolonged periods of time. Phosphates and phytates included in the diet will form insoluble salts with iron and thus render it unabsorbable.

INTERNAL FACTORS

USING the double isotope technic, Bothwell, *et al.*[10] have demonstrated that the rate of absorption of ferrous iron is directly related to the rate of marrow erythropoiesis and inversely related to the amount of iron stores in the body. Maximal absorption occurred with the combination of increased erythropoiesis and depleted stores, and was minimal with decreased erythropoiesis and saturated iron stores. Absorption was normal when both erythropoiesis and stores were increased, the effects apparently neutralizing each other. These results were obtained regardless of the level of anemia or plasma iron saturation. Thus, in deficiency states, the amount of iron absorbed is modified by the factors listed in Table 1 and in deficiency states, may be increased from two to as much as ten times the normal amount.

TABLE 1.

FACTORS IN IRON ABSORPTION

LOCAL	INTERNAL
A. Dietary	A. Rate of Erythropoiesis
1. Ionic form	
2. Total amount	
3. Reducing substances	
4. Insoluble salts	
B. Mucosal	B. Body Iron Stores
1. Bowel gradient	
2. Mucosal saturation	

At this point mention should be made of iron absorption as it applies to the infant. It seems probable from the work of Smith, *et al.*,[12] that the only iron utilized for hemoglobin synthesis by the newborn infant during the first six months of life, is that which it acquired transplacentally from the mother during the last month of gestation. This iron is not normally utilized until after six months of age.

IRON TRANSPORT

FROM its temporary storage site in the mucosal cell, iron gains access to the blood stream by crossing the vascular side of the cell membrane in the divalent state. Once in the blood stream, it is bound to a beta-1-globulin, transferrin,[11] and is transported in the ferric form to the sites of utilization and storage. There is no direct exchange between plasma iron and the iron in the red cell. Normally, transferrin is only one-third saturated with iron. This saturated portion measures about 130 micrograms per cent. This level, and the capacity of the unsaturated plasma protein to bind additional iron forms the basis of a useful chemical determination[13] which can be applied to clinical situations. It usually reflects the amount of

iron in body stores and can thus indicate the need for supplemental iron. The relationship of the serum iron and the iron-binding capacity of the serum as it is found in several clinical situations is illustrated in figure 3.

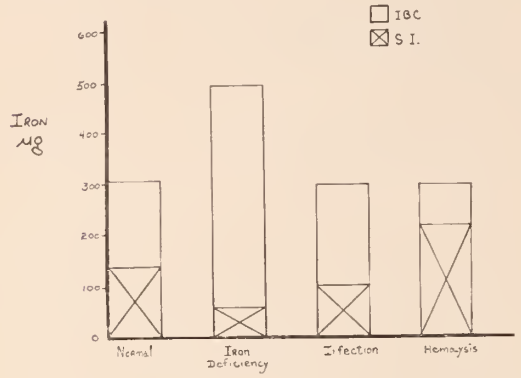


Figure 3. Relationship of serum iron and the iron-binding capacity of plasma proteins in several clinical situations. In the normal, the iron saturation of the protein is approximately one-third and measures about 130 micrograms per cent. In iron deficiency the serum iron level is decreased, with a marked increase in the unsaturated iron-binding protein. During infection and inflammation, hypoferremia results from failure to fully reutilize the iron liberated from senescent red cells. A slight decrease in the unsaturated iron-binding protein has not been fully explained. In hemolytic states, the serum iron is increased with a larger fraction of the protein saturated with iron.

IRON STORAGE

THE main sites of storage are in the liver, marrow, spleen and other reticuloendothelial organs. The major portion of the iron in the spleen represents that derived from the daily breakdown of old "worn-out" red blood cells. Normally 1/120th of the red cell mass is destroyed in the spleen per day. This involves the liberation of approximately 20 to 25 milligrams of iron daily. With hemolysis, this amount may become markedly increased, saturating the iron-binding protein, and in severe situations become deposited in the tissues.

Iron is stored in two chemical forms, both available for use in the synthesis of hemoglobin. Normally, 60 to 70 per cent are stored as ferritin, containing 17 to 23 per cent of iron by weight.[14] Ferritin is water-soluble and cannot be demonstrated by staining technics. Hemosiderin, the other form of iron store, contains 35 per cent of its weight as iron, is insoluble and can be demonstrated microscopically either unstained or stained with suitable dyes. Excess iron is stored as hemosiderin,[15] so that examination of the marrow spicules for hemosiderin furnishes a reliable means of assaying iron stores and the need for supplemental iron.[16] The hemosiderin in the marrow spicules are seen as granular, intracellular, grape-like clusters in the anemias associated with increased erythropoiesis. The increased hemosiderin deposits accompanying aplasia, infection and uremia, are in the form of amorphous accumulations.[17]



Figure 4.—Bone marrow spicules stained for iron. Specimen was obtained from a patient with hereditary spherocytosis in crisis. Note the grape-like clusters of iron granules present in situations in which there is a rapid iron turnover (i.e.—hemolytic anemias).

When absorbed from the gastro-intestinal tract, iron is stored mainly in the liver parenchymal cell. Administered parenterally, whether as saccharated iron, iron-dextran or as transfused red cells, it is first deposited in the reticuloendothelial system.

IRON IN THE RED CELL

THE iron made available by the reticuloendothelial system from hemoglobin breakdown is utilized in the resynthesis of hemoglobin preferentially over the iron stored in the liver parenchyma.[18] The hypoferremia which may

be present in inflammatory states, and which is depicted graphically in figure 3, results from a failure fully to reutilize the iron liberated from senescent red cells.[19] Josephs[20] has also shown that injected iron, diverted to the reticuloendothelial system, is incorporated into the hemoglobin molecule with much more rapidity than that absorbed from the gastro-intestinal tract. From these observations, he suggests that the iron in the reticuloendothelial system is utilized for the day to day synthesis of hemoglobin.[21] Iron stored in the liver, however, is not readily available, requires anoxia



Figure 5.—Bone marrow spicules stained for iron. Specimen was obtained from a patient with "aregenerative" anemia in which very little red blood cell activity was noted. Note the large amorphous accumulations of iron. Patient had been treated with parenteral iron before completely evaluated.

for its release from ferritin,[22] and would therefore serve as a reserve for that lost by hemorrhage.

With these principles in mind, 35 patients manifesting chronic hypochromic anemia due to iron deficiency were treated with an intramuscular iron-dextran preparation† by Sawitsky and Nussbaum.[23] Bone marrow studies for iron stores, serum iron and iron-binding capacity determinations were obtained to confirm the impression of iron deficiency, prior to institution of therapy. The total duration of treatment ranged from 5 to 70 weeks and dosages administered varied from 100 milligrams to 7200 milligrams. In all cases, there was a significant and rapid improvement in the hemoglobin level from 0.7 Grams per cent to 2 Grams per cent within 10 to 14 days, approximately twice the levels attained in a similar length of time with oral preparations.[24] One of these patients, with hereditary hemorrhagic telangiectasia and status post-gastrectomy, required numerous transfusions, on an average of one unit of whole blood every 3 to 4 weeks, and was intolerant to oral iron. Upon the institution of intramuscular iron, fewer transfusions were necessary, even in the face of continued blood loss. Therapy was continued without side effects for 70 weeks for a total dose of 7200 milligrams of iron. Hemoglobin levels were maintained at a higher plateau of about 11 Grams per cent during most of this period.

IN USING intramuscular iron, it is emphasized that hypochromic anemia due to iron deficiency in adults is a symptom of a basic disturbance, most usually involving hemorrhage. Before administering iron, the hypochromic and microcytic anemia due to iron deficiency must be differentiated from that accompanying thalassemia syndromes, the hemoglobinopathies, chronic inflammatory diseases and hereditary hypochromic anemia with high serum iron, in which iron stores are plentiful and where indiscriminate administration might lead to hemosiderosis. Examination of the marrow spicules for iron, either stained or unstained is simple and is the most accurate means of assaying iron stores, thereby determining the need for supplemental iron. This examination should always be done prior to the institution of parenteral iron therapy.

Parenteral iron may be used effectively and safely for prolonged periods of time, but is indicated (1) only in the presence of gastrointestinal disease, which would be adversely affected by the irritation of oral iron, (2) where there is intolerance to oral iron, (3) if there is poor oral absorption, and (4) in situ-

†Imferon-Benger-Lakeside.

ations which require rapid restoration of iron stores. Lack of an adequate response to a course of parenteral iron calls for complete re-evaluation of the patient and a search for complicating factors such as infection, inflammation or uremia and not for the administration of more iron. *Once iron enters the body, it cannot be removed except by bleeding.*

The Seton Hall College of Medicine and Dentistry

A bibliographic listing of 24 references appears in Dr. Nussbaum's reprints.

Heart Disease and Work

Writing in the February 1959 *Journal of American Insurance*, Dr. Paul Dudley White says that "heart disease and industry are not incompatible. The trained mind of a cardiac cripple may be more valuable in industrial progress than a body in perfect health controlled by a dull intellect." Discussing the relationship between work and heart disease, Dr. White then adds:

Rheumatic heart disease is not caused by work. Given a good deal of rheumatic heart disease, work can be an aggravating factor, but it is an unusual reaction to the hemolytic streptococcus that actually causes rheumatic heart disease.

Hypertension has not been shown to be the result of hard work, mental or physicial. Some of the healthiest people I have ever known have had normal blood pressures at the age of 80, 90, or 100 or more—nervous people who have worked hard all their lives.

Nor is there any proof that *coronary heart* disease *per se*, that is coronary atherosclerosis, is caused by hard work, mental or physical, though such may be an aggravating factor, and not causative. However, we haven't all the information yet, and it is conceivable that hydrodynamic factors in the range of biophysics, not yet adequately investigated, may perhaps play an early role, but not necessarily in everyone.

Work is important for health; many of us use it as a therapeutic measure for cardiac patients both in rehabilitation after a heart attack, for example, and in keeping them well.

I would like to emphasize the beneficial effect of work on body, mind, and soul in any occupation in which it is possible for a cardiac patient to engage. Idleness breeds unhappiness and is bad for the health. It is a rare patient indeed who is fit for nothing. It greatly pays to make every effort to find something, either vocation or avocation, into which to fit the sick man or woman, either.

One of our greatest challenges is to make it possible, on the one hand, for cardiac patients to secure jobs despite the fear of employers to accept them, and on the other hand, to exonerate industry from the unwarranted blame of hurting the heart. I have just said that work is good for a person's health and at least as important, if not more so, for a cardiac (within his capacity) as for a normal person. Therefore, to deprive a crippled person of an important therapeutic help in the form of a job is not only an unsound policy but also an unfair discrimination.

Elliot Rinzler, M.D.
Wade N. Miller, M.D.
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Newark

The Positron Brain Scanner in the Diagnosis and Localization of Intracranial Lesions*

The electronic age is indeed invading medicine. Here is a report of an instrument which sounds like something out of Science Fiction. Fortunately, however, it is all science and no fiction.

Radioactive isotopes for localization of intracranial pathology, particularly tumors, have been used for some time.[1] Localization is possible because of a differential absorption or uptake of the radioisotope between the tumor and normal brain tissue. If it is desired to find a lesion without operative procedure a gamma ray-emitting isotope must be used, the radiation of which has sufficient energy to traverse the brain and skull and still be counted by an external counter.

K-42 in the form of potassium chloride and I-131 in the form of diiodofluorescein and radioiodinated human serum albumin (R.I.S.A.), have been used.[2,3]

The definition of the lesion is not very precise with gamma radiation because of the recording of rays coming into the scanning head at various angles. To overcome this Sweet and Brownell[4] investigated the use of positron-emitting elements.[5] As-74 and Cu-64 were found to be the most useful. When a positron is emitted it is very short-lived and travels for a millimeter or less before it gathers and unites with an electron. This electron-positron combination of matter is then annihilated into energy, which goes off as two gamma ray photons 180 degrees apart. Brownell and associates[4] have devised a scanner which picks up this positron annihilation radiation (See Figure 1). Two scintillation counters move together, scanning the head. They are connected to a circuit so that a recording is made only when both counters receive gamma rays simultaneously, which occurs only for positron emission. This type of scan gives better definition of the source of radiation than does the ordinary gamma ray scan.



Figure 1. Positron Scanner

*This work is from the Radioisotope Department, The Presbyterian Hospital in Newark, New Jersey.

The same two counters are connected to another circuit called the anti-coincidence circuit in such a manner that only when one side receives more gamma radiation than the opposite side is a recording made. The farther off center the source of radiation, the greater are the number of prints, or conversely, the greater the number of either right or left prints the more removed from the center is the emitting lesion.

Thus one has a twofold means of localizing a lesion, (1) by the positron scan, also called a positrocephalogram, and (2) by the anti-coincidence or asymmetrogammagram.

For better three dimensional localization, the patient's head is turned 90 degrees so that the face is toward one counter and the back of the head is toward the opposite counter. The positron scan may now show where the lesion is in the coronal plane.

Using simultaneous recording of positrocephalogram and asymmetrogammagram, Sweet and Brownell[4] were able to obtain a high degree of localization. The meningiomas gave the best definition and glioblastomas second best. Slow growing, avascular tumors and those invading the brain stem, ventricle, and sella gave poor accuracy. In the latter group a very small mass may give many symptoms and yet not concentrate enough of the isotope to produce a discernible scan.

This aid in diagnosis and localization of intracranial lesions is a valuable adjunct to conventional neurosurgical diagnostic procedures. An intravenous injection of As-74 is all that is needed, and after one hour the simultaneous scanning of positron annihilation and gamma radiations is ready to be made.

Two cases are reported in which scanning gave interesting and accurate information vital in localizing the lesion to be operated.

FIRST CASE

A thirteen year-old boy suddenly complained of headache. The following afternoon he was found unconscious and was taken to another hospital. He regained consciousness within a few hours. X-rays of the skull were found to be normal and he was released. On his way home he had a convulsive seizure, lost consciousness again and was taken to a second hospital. Here a spinal tap was done, revealing a pressure of 240 millimeters, with 42 lymphocytes per cubic millimeter. In the evening the child was transferred, by the family doctor, to the Presbyterian Hospital.

The admission diagnosis was encephalitis. The patient was semi-conscious and did not respond to questions and orders. The eyes tended to deviate to the left. He had bilaterally positive Babinski reflexes and absent abdominal reflexes. The percussion note was higher on the left side of the cranium than on the right.

Spinal tap, two days later, showed clear, colorless fluid, ten lymphocytes per cubic millimeter and 29 milligrams per cent of protein.

The following day he was still semicomatose and developed signs of a right hemiplegia with deep reflexes more active on the right. Abdominal reflexes were absent on the right but present on the left. Cracked pot percussion was found on the left side of the head. The clinical diagnosis of left fronto-temporal subdural fluid was made by the neurosurgical consultant.

The brain was scanned the same day. The positrocephalogram, Figure 2, did not show any discernible increase in uptake. However, the asymmetrogammagram, Figure 3, showed curved prints in the region of the right temporal lobe. A curved print is made when the right counter picks up more gamma radiation than the left counter. Since the positrocephalogram did not show an increased isotope uptake, it was concluded that this asymmetrical finding could only be due to below normal uptake in the left temporal region. This decreased uptake would most likely be due to fluid accumulation in this region, such as cyst, hematoma or cerebrospinal hygroma.

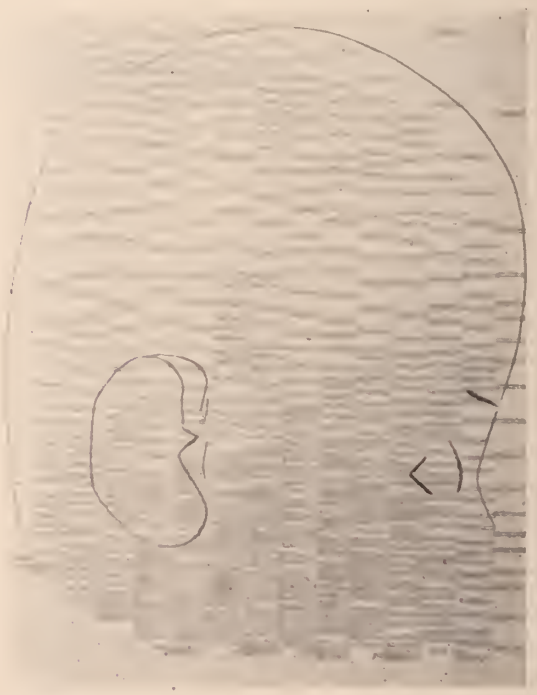


Figure 2. Positrocephalogram of H., Case 1.

The following day bilateral burr holes were drilled. The dura was incised and 60 cubic centimeters of subdural fluid were evacuated from the left temporal subdural space.

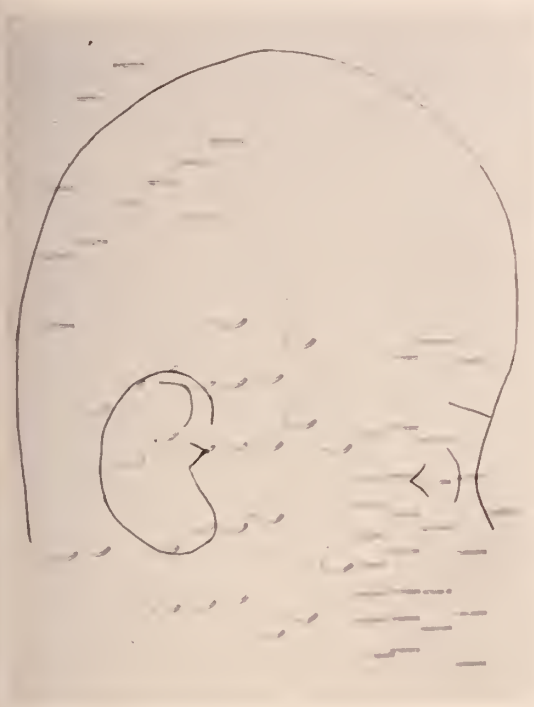


Figure 3. Asymmetrogammagram of H., Case 1.

SECOND CASE

A thirty-three year-old woman complained of sudden weakness in the right foot and leg. She was admitted to the Presbyterian Hospital the following day. She had right foot drop without sensory changes. Within a few days the Babinski became positive in the right foot and deep reflexes were increased. The next day early papilledema was noted. Spinal tap, the same day, showed a pressure of only 5 millimeters of mercury, one lymphocyte per cubic millimeter and 52 milligrams per cent of protein. Soon thereafter, the papilledema increased. Ten days later there were bilateral pyramidal tract signs greater on the right than on the left. On the 20th day after admission, pneumoencephalogram with a small amount of air was done. No air reached the cranial cavity, suggesting a posterior fossa block. Five days later, a ventriculogram was highly suggestive of a high left supratentorial lesion (Figure 4).

To give further localization a brain scan was done the next day. The positrocephalogram is shown in Figure 5. The region of increased prints leaves no doubt as to the localization of the tumor in the anterior parietal area near the vertex of the skull. Notice how clear is the definition of tu-

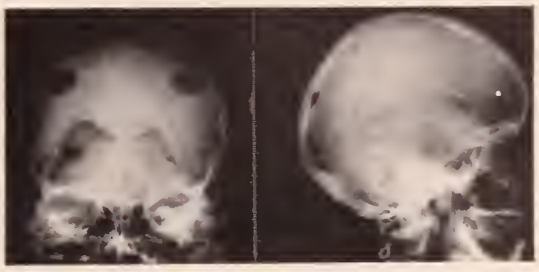


Figure 4. X-ray of Mrs. G., Case 2.

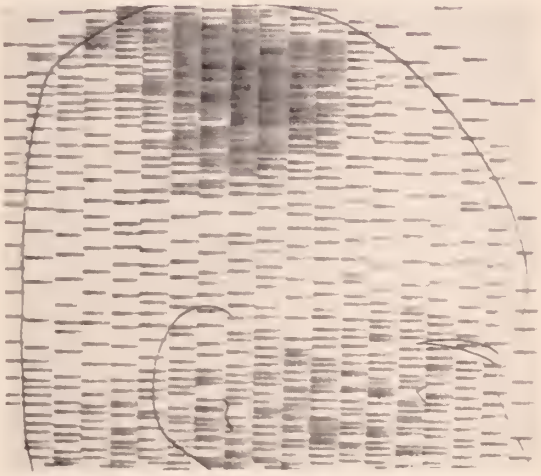


Figure 5. Positrocephalogram of Mrs. G., Case 2.



Figure 6. Asymmetrogammagram of Mrs. G., Case 2.

mor. The asymmetrogammagram in Figure 6 shows that the lesion is to the left. The patient's head was also scanned in the coronal plane. This positrocephalogram is shown in Figure 7 with the lesion clearly indicated. Thus the lesion is localized in three dimensions.

This patient was operated on 6 days later. A meningioma was found in the left anterior parietal region, parasagittally as shown in the scans.

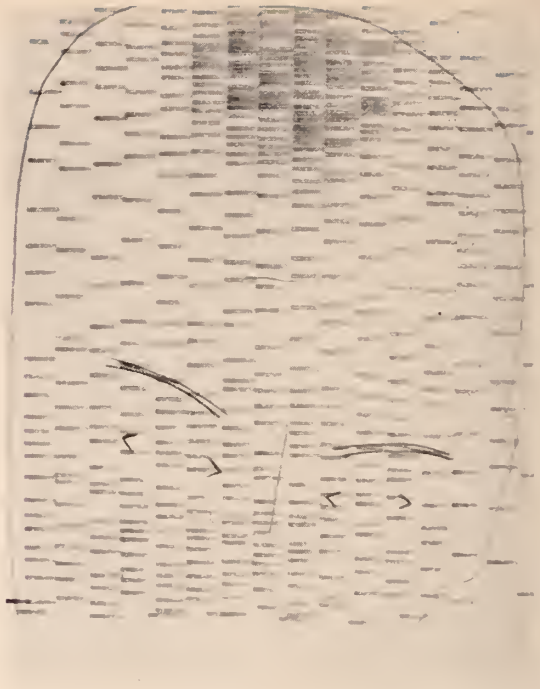


Figure 7. Lateral Positrocephalogram of Mrs. G., Case 2.

SUMMARY

THE benefits of positron brain scanning in localizing intracranial lesions have been reviewed.

Two illustrative cases are presented and discussed.

We wish to thank the Black Stevenson Foundation and the Cancer Bureau of the New Jersey State Department of Health for their grants to us and Mr. William Hillsinger for his technical assistance.

27 South Ninth Street

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George A. Rogers, M.D.

Camden

Alcoholism Treated with Prochlorperazine*

Anyone who has anything to offer for the management of the alcoholic merits a respectful hearing. Dr. Rogers asserts that "favorable responses" were achieved with prochlorperazine in 10 out of 29 chronic alcoholics. That ratio—about 33 per cent —is better than reported by most workers in the field of chronic alcoholism.

Prochlorperazine,* a relatively new drug related to chlorpromazine, shares in some degree with its congener several properties, both pharmacologic and clinical. Although less suppressive of motor activity,[1] prochlorperazine blocks the conditioned escape response in rats more effectively than dose chlorpromazine.[2] Prochlorperazine* also has more potent antiemetic activity in dogs against experimentally induced emesis than does chlorpromazine.[2]

Prochlorperazine,* like chlorpromazine, has been reported to be effective in a variety of psychiatric disorders including anxiety[3] and tension states,[4] manic excitement,[5] and behavior problems.[6] The drug has been reported to exhibit effective and prompt antiemetic action in pregnancy,[7] and nausea and vomiting associated with malignant[8] and other diseases.[9] There have been no published reports of serious side effects, including liver dysfunction, blood dyscrasias, or severe hypotension accompanying the use of prochlorperazine.

Because of these facts, and because of previous successful management of alcoholic patients by us and others, particularly Fazekas, Rea, and Shea,[10] Cummins and Friend,[11] and Fox,[12] with chlorpromazine, we recently undertook to study prochlorperazine* clinically at the alcoholism clinic of West Jersey Hospital. In this project, we gave prochlorperazine* to 46 patients suffering severe, chronic alcoholism of 5 to 15 years' duration. The group

*Available under the Smith, Kline and French tradename of Compazine®.

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included 37 men and 9 women; their ages ranged from 28 to 65.

Twenty-seven of the patients when first seen were acutely ill as a result of "spree" or "binge" drinking. Most of them had symptoms of post-intoxication withdrawal. The other 19 patients, simply seeking relief from their alcoholic addiction, were first seen during the "chronic" phase of their illness. All 46 had symptoms of anxiety and tension and avitaminosis plus a certain amount of character disorder, or psychomotor agitation. Three of the acutely ill patients, in addition, showed brief and transient hallucinations, and one patient delirium tremens.

All but four of the 27 alcoholics who were acutely ill were given prochlorperazine* parenterally in an attempt to relieve their withdrawal manifestations, including psychomotor agitation and retching; the remaining four were given the drug orally. At the outset of the investigation, single intramuscular doses of 5 or 10 milligrams of the drug were administered. As we gained experience, acutely ill patients received doses of 20 or 30 milligrams intravenously and, frequently within 30 minutes, another dose if indicated. Patients were usually required to lie down to receive the drug. Blood pressures were recorded for most patients before the drug was administered, but it was often impossible to obtain post-drug blood pressure readings because the patients would walk out of the hospital's busy accident ward too quickly.

The four acutely ill patients who were started on oral prochlorperazine* received 10 to 40 milligrams daily. All acutely ill patients (once control of symptomatology was achieved, either partial or full) were given the oral form of the drug in dosages varying from 10 to 40 milligrams daily. The most common dosage was 10 milligrams three times a day.

The 19 patients first seen in the "chronic" phase of their illness were immediately started on oral prochlorperazine.* Average dosage was 30 to 40 milligrams daily, although a few patients received as much as 125 milligrams daily. The dose was adjusted according to the individual patient's needs.

Acutely ill patients requiring oral medication only were observed for an hour after they received the drug. If intravenous prochlorperazine,* or intravenous fluids of any nature, were required, patients were asked to remain in the accident ward for two to six hours. (Three of the acutely ill patients were also admitted to the hospital for four to seven days.) When, however, a patient was considered still to be in the "acute" phase (as evidenced by marked agitation, tremors, insomnia, and restlessness) he was asked to return to the clinic every day until his symptoms disappeared. After treatment for the acute phase of his illness, each patient was encouraged to return to the clinic voluntarily for treatment of the basic psychic disturbance responsible for his alcoholism.

Duration of therapy for about one-fourth of the total of 46 patients varied from six to ten months; and for another fourth, one to two months. The remainder were treated only during the acute phase of their alcoholism.

All patients were evaluated physically to the extent indicated. Laboratory tests, when called for, included electrocardiograms, gastrointestinal x-rays and blood studies. In general, however, complete and thorough physical evaluations were carried out on only those patients who remained under treatment for two months or more. The acuteness of emotional disturbance experienced by many patients precluded earlier complete evaluations.

Supportive measures for patients (either acute or chronic) when indicated, included vitamin and dietary therapy. When malnutrition or dehydration appeared marked, especially in acutely ill patients, intravenous fluids were also given. Some patients requiring night time sedation were given barbiturates. As soon as practicable, psychotherapy, generally of a supportive nature, was instituted with cooperative patients. The aim of this therapy was to help the patients accept alcoholism as an expression of a personality disturbance. The hope was that this acceptance would enable him to continue with insight-type psychotherapy. Supportive psycho-

therapy helped keep many patients "dry" for varying periods. However, true insight therapy was accomplished with but a few patients—an expected, although disappointing result. During psychotherapy, prochlorperazine* was administered as adjunctive therapy in an effort to reduce agitation and tension.

RESULTS

Evaluation of the results of therapy with prochlorperazine* was largely empiric, made in the light of long experience with alcoholics. We did not expect, for example, that many, if indeed any, of the chronic alcoholics would entirely forego alcohol within the space of a few months' treatment. Significant reduction in alcohol intake, however, and control of anxiety and tension were considered to be realistic expectations for some of the patients. As an antiemetic, the drug was expected to control most of the symptoms of nausea and vomiting. As a tranquilizer, it was expected to calm hyperactive patients.

When it was our impression that the drug had been one of the more important factors in reducing the patient's symptoms—anxiety, tension, agitation, nausea, vomiting, and uncontrollable craving for alcohol—the response was considered *favorable*. When we felt the drug to be helpful, but not a major factor in the improvement of the patient's symptoms, the response was considered *satisfactory*. When we felt that none of the patient's symptoms were controlled, the response was considered *unfavorable*. Side effects, when they interfered with therapy, naturally influenced these ratings.

Prochlorperazine* proved to be of most benefit in the treatment of the acute phase of alcoholism. Of the 27 acutely ill patients, 20 responded favorably, six satisfactorily, and one unfavorably to prochlorperazine* therapy. All 23 acutely ill patients (of 27) who initially received the drug parenterally benefited in some degree; three of the four who initially received the drug orally also benefited. When 19 of 23 patients were subsequently transferred from parenteral to oral medication, four patients responded unfavorably.

Of the 46 patients seen in this study, only 29 continued treatment long enough to evaluate the effect of the drug on their chronic symptomatology. The other 17 may not have returned because their desire for alcohol was temporarily decreased, because they were in the throes of another alcoholic episode, or because they were undergoing treatment elsewhere.

Of the 29 patients who were followed for three or more visits, 10 patients—or a little over one-third—responded favorably; 14 patients responded satisfactorily; and five patients, unfavorably.

Side effects were mild and infrequent. Drowsiness was seen in three patients receiving an oral dosage of 100 to 125 milligrams of prochlorperazine* daily, and extrapyramidal symptoms in a third patient receiving 80 milligrams a day. Reduction of dosage alleviated the drowsiness and discontinuance of the drug caused the extrapyramidal symptoms to disappear. Two patients, one receiving 40 milligrams of prochlorperazine* daily and the other a single dose of 10 milligrams parenterally, complained of a feeling of "nervousness." Barbiturates helped the first patient; the second never returned to the clinic. One patient experienced a slight urticaria accompanied by chills and a rash. When the drug was withdrawn these symptoms disappeared only to return on resumption of drug therapy. No patients experienced any vein irritation upon intravenous administration, and there were no marked hypotensive reactions. One patient experienced a hepatic insufficiency, apparently not related to prochlorperazine* therapy but rather to an existing chronic cirrhosis. This was not aggravated by the drug.

Four of the chronic alcoholic patients preferred other drugs: two, meprobamate; one, a dextro-amphetamine and amobarbital combination; and one, glutethimide (to which he later became addicted.)

COMMENT

The use of psychopharmacologic (or tranquilizing) agents as adjunctive therapy in the treatment of alcoholism has become so common these days that any generalized com-

ments are more or less superfluous. There are, however, some specific effects of prochlorperazine* which do seem to be worth mentioning. These are:

1. Prochlorperazine,* unlike chlorpromazine, produces little drowsiness or lethargy. Although there are times when a hypnotic effect is desirable in alcoholics, more often such an effect is not acceptable to the patient.

2. There was no apparent pain on intramuscular or intravenous administration of prochlorperazine.* For this reason, and since hypotension appeared to be virtually non-existent, we felt little reluctance to make use of the parenteral form of the drug, and hence, were able to control promptly all of the acute, generally impatient alcoholics.

3. Prochlorperazine* has been reported to exert only an additive rather than a potentiating effect upon narcotics. This means that the attending physician need not be as concerned (as he often must with other tranquilizers) about the possibility that the patient himself may have taken narcotics or that well-meaning associates of the patient may have administered them. Alcoholic depression of the central nervous system is also apparently not deepened by prochlorperazine.*

This non-potentiating effect of prochlorperazine* is of obvious advantage in our clinic, where sodium phenobarbital is often administered along with a tranquilizer. The rationale for such treatment, in our opinion, lies in the fact that tranquilizers, unlike barbiturates, do not act as substitutes for the alcohol which has been withdrawn abruptly.

4. The low incidence and severity of side effects encountered with prochlorperazine* in this evaluation is not necessarily a true measure of what might be encountered with the drug in a larger, more diverse series of patients. However, it implies at least that prolonged therapy is safe and that the patient will not discontinue the drug voluntarily as a result of toxic manifestations or side effects.

SUMMARY AND CONCLUSIONS

PROCHLORPERAZINE* was given to 27 patients who displayed symptoms common to acute alcoholism. Of these, 23 received the drug parenterally, four by mouth. Favorable responses were achieved by 20 patients, satisfactory responses by six, and an unfavorable response by one. Of 29 patients treated for "chronic" alcoholism, 10 patients achieved favorable responses, 14 satisfactory responses, and 5 unfavorable responses. Side effects, aside from extrapyramidal symptoms experienced by one patient, were mild and infrequent.

Not only for the patient, but for the physician who treats him, prochlorperazine* is an effective agent for the control of psychomotor agitation and retching of acute alcoholism. In postalcoholic states, the drug relieves anxiety and tension, thereby reducing the desire for alcohol, improving appetite and sleep patterns, and facilitating the psychotherapeutic relationship.

524 Cooper Street

Penicillin and Salk

Persons with a history of penicillin allergy should ask their doctors for penicillin-free vaccine when receiving polio shots, advises Dr. Murray C. Zimmerman of Whittier, California. There is sufficient penicillin in most polio vaccines "to cause allergic reactions in exceptional patients highly sensitive to penicillin." If penicillin-free vaccine is unavailable, Dr. Zimmerman suggests an injection of penicillinase before the poliomyelitis vaccination is given.—*Journal of the Maine Medical Association*, September, 1958.

Donald P Burt, M.D

Morristown

Methyl Salicylate Poisoning*

Case Report with Review of the Literature

A pleasant little flavor is wintergreen: loved by children and adults alike. Yet a teaspoonfull of wintergreen may be as fatal as that much cyanide. What can be done about it? Dr. Burt has an answer.

This review was stimulated by experience with a fatal case of methyl salicylate poisoning. Newer technics for determining acid-base balance are becoming available for use in general hospitals. This, plus more widespread use of the artificial kidney, warrants a review of this severe form of poisoning and a summary of the present concepts of diagnosis and treatment. The basic tenets of methyl salicylate poisoning apply to other salicylates, such as the sodium or acetyl derivatives, the only difference being the greater depth of toxicity of the methyl form. This is presumably due to the high concentration of salicylate in preparations containing this drug.

PHARMACOLOGY

Oil of wintergreen was originally prepared from an extract of gualtheria leaves and was about 95 per cent methyl salicylate. Today, oil of wintergreen is generally synthetic, but it still contains about 95 per cent of the pure drug; only recently has a poison label been included on the bottle.[5] Its main use is as a liniment; it is included in some ointments, and is occasionally used in small amounts as a flavoring agent. The sweet taste of the liniment makes it particularly attractive to small children. A distinctive feature of this form of salicylate is that one teaspoonful of oil of wintergreen contains from 45 to 65 grains of salicylate.[4]

INCIDENCE AND MORTALITY

In 1799 fourteen soldiers became ill after ingesting gualtheria leaves, which is the first recorded such case in the available literature.[1] Since that time, and not including the 14 just mentioned, 95 case reports have appeared in the literature, the latest[21] being in 1957. The case reported here brings the total to 96. Of these, 43 died, a mortality of 45 per cent. There was one additional death due to the external use of the drug.[11] These figures fail to give the true incidence. This is shown by data[24] from *Vital Statistics of the United States* which reported 526 fatal cases of salicylic poisoning from 1933 to 1943, 62 per cent of which were due to methyl salicylate (326 deaths). In 1951 there were 34 deaths. In the following year, 38 deaths were reported in the United States from methyl salicylate (38 and 34 per cent respectively of the total salicylate deaths reported). Since 1952 the statistics have not been broken down into specific types of salicylates.

The smallest fatal dose in a child is reported as 4 cubic centimeters and 6 cubic centimeters

*From the Morristown Memorial Hospital.

in an adult. The largest reported dose with recovery in a child is 30 cubic centimeters, while several adults have recovered after ingesting 30 cubic centimeters.

DISTRIBUTION AND EXCRETION

The peak in the plasma level of ingested sodium salicylate in adults is reached in about 1½ hours. Aspirin is absorbed a little slower, shows a lower peak level in the plasma, falls at a slower rate and is excreted in 15 to 30 hours. Methyl salicylate shows a much slower absorption from the intestinal tract, the peak plasma level occurring as much as six hours after ingestion and in some cases much longer. The drug has been found to be equally distributed in all body fluids including the spinal fluid. About 70 per cent is excreted in the urine, some in the sweat, and about 20 per cent oxidized in tissues. After ingestion of the methyl form, about 50 per cent is excreted in the first 24 hours and is still found in the urine up to 3 days.

PATHOLOGY

Pathological findings at autopsy may include: acute gastritis, hyperplasia of the gastro-intestinal tract; edema and fatty degeneration of the liver; acute degenerative nephritis; congestion and edema of lungs; edema of the brain; and small hemorrhages in pleura, pericardium, and subdurally.

Various theories of the mechanism of salicylate toxicity have been proposed. One was that primary acidosis was responsible for the hyperpnea. Another was that salicylates directly increased the basal metabolic rate. It was held that methyl salicylate was converted to methyl alcohol and the latter was responsible for the toxic effects in man. Although methyl salicylate is partly converted to methyl alcohol in the intestines, the amount so derived is too small to be of any importance. The true course of events has been shown to be an initial central nervous system stimulation with resultant hyperpnea and blowing off of carbon dioxide producing alkalosis,[10] followed by a primary metabolic acidosis.[18] In overwhelming poisoning, the alkalosis and acidosis may seem to occur at once. The initial effect of the respiratory alkalosis is a lowered blood carbon dioxide. As compensation, the buffer bases are excreted in greater amounts by the kidneys. With more toxic doses there ensues a metabolic acidosis apparently due to a direct effect of the salicylates on the tissues with an increase of organic acid metabolites. The ordinary laboratory data will be difficult to interpret at any given moment because of the action of these two factors at the same time. Still larger doses depress the central nervous system, with respiratory failure. Capillary permeability is increased and the prothrombin time becomes prolonged, which may lead to hemorrhages.

SYMPTOMS

Symptoms of salicylate poisoning include: nausea, vomiting, diarrhea, profuse sweating, flushed face, injection of conjunctivae, tinnitus, headache, and hypernea. Hemorrhagic manifestations may become apparent. As the course progresses there is marked excitement, delirium, then coma, respiratory depression, and death.

CASE REPORT

A 45-year old woman with rather advanced rheumatoid arthritis drank about 70 cubic centimeters of oil of wintergreen in an attempted suicide. An hour later, vomiting was induced with a finger in the throat. She was given a glass of sodium bicarbonate and vomiting was induced again. There were no symptoms of toxicity at this time, but she was placed in the Morristown Memorial Hospital where stomach lavage was done with about one liter of water, and until all oily appearance had disappeared from the returning fluid. An hour later, she began to sweat, and vomiting was involuntary. Blood pressure at that time was 208/116, pulse 120. Two hours after admission, she complained of tinnitus. Her face was flushed. There was marked restlessness and excitement. Sixth molar sodium lactate was given intravenously. Within two hours thereafter, she was delirious. Blood pressure was 170/80, pulse 110, condition

critical. More sodium lactate was given intravenously and this was later repeated. She was placed in an oxygen tent. Though restless and hyperpneic, she lapsed into coma 7 hours after admission at which time blood pressure was 208/110 and pulse 120. She died rather suddenly one hour later.

At autopsy, the odor of oil of wintergreen was unmistakable. Clinical examination of the blood obtained at autopsy revealed a methyl salicylate level of 104 mgm. per cent. Pertinent findings were acute passive congestion of both lungs, cerebral edema, passive congestion of the pituitary gland, and mild fatty degeneration of the liver. No hemorrhages were found. There was a small, microscopic, acute ulceration extending to the muscularis mucosa in the duodenum. There was no other evidence of gross or microscopic salicylate toxicity. Other findings were generalized arteriosclerosis, follicle cyst of ovary, and rheumatoid arthritis of the one joint examined.

The use of certain terms describing acid base balance is confusing. A review is desirable for clarification. The maintenance of the blood pH at the values compatible with life (7.0-7.8) in the main depends on four factors. One is the buffer systems of the blood which consist of weak acids and their salts. Another is the blood proteins, particularly hemoglobin, which can combine with or give up oxygen. The third factor is the ability of the lungs to get rid of large quantities of carbon dioxide. The fourth is the excretion of acid or base by the kidneys.

Carbon dioxide concentration refers to the amount of carbon dioxide dissolved in the plasma. In the literature, it has also been used interchangeably with the term carbon dioxide content. Carbon dioxide pressure or pCO_2 refers to the partial pressure of carbon dioxide dissolved in plasma and is equivalent to the carbon dioxide pressure of alveolar air. This determination is of help when respiratory acidosis or respiratory alkalosis is present. Carbon dioxide content, on the other hand, is more complex. The carbon dioxide content measures the total amount of buffer base with the exception of hemoglobin and other buffer proteins. The carbon dioxide combining power as determined by the method of Van Slyke actually measures the carbon dioxide content of a sample of blood which is exposed to an atmosphere of carbon dioxide of 40 millimeters partial pressure (the technician blows his own breath on the sample of blood to be analyzed). In situations of metabolic acidosis or alkalosis this method has an error of about 5 per cent and is clinically satisfactory. In respiratory acidosis or alkalosis, where the blood in the body is actually exposed to carbon dioxide of much lesser or greater degrees of partial pressure, the carbon dioxide power becomes inadequate. This holds true in salicylate poisoning where both respiratory alkalosis and metabolic acidosis are simultaneously present.

In most of the medical literature, *buffer base* means the amount of HCO_3 in the blood, as measured by the carbon dioxide content (or carbon dioxide combining power). This does not include the hemoglobin buffer system. When the later is taken into account and added to the amount of "buffer base," the sum is called the "total buffer base," and represents a more accurate picture of the situation.

Singer and Hastings[19] have devised a more accurate way of diagnosing the state of acid-base balance at any given moment. From hematocrit (or hemoglobin), blood pH, and whole blood carbon dioxide content (arterial or whole blood carbon dioxide is more accurate than venous blood), they are able to calculate the pCO_2 (equivalent to the pCO_2 of alveolar air) and total buffer base of whole blood. From these values they have constructed a normogram, reference to which quickly establishes the buffer base deficit for any given patient.

From the clinical standpoint, the important thing is to determine as accurately as possible the buffer base deficit so that replacement therapy can be given. This can best be done by drawing blood from the patient for determination of hematocrit (or hemoglobin), arterial or whole blood carbon dioxide content, and blood pH, and then using the normogram of Singer and Hastings. Harvie and Singer[6] describe a method of determining whole blood carbon dioxide in children by obtaining a sample of heparinized capillary blood by heel puncture.

These determinations require a laboratory capable of doing pH and carbon dioxide content. In laboratories where such equipment is not available, a venous carbon dioxide combining power will have to suffice, until at least

a pH meter can be obtained. Values for carbon dioxide combining power alone in this situation can be misleading if taken as a reflection of the true state of acid-base balance, and at best are only rough guides. Clinical judgment must play an important role.

TREATMENT

General Measures:[18] The initial procedure is gastric lavage with water. It is probably *not* advisable to use sodium bicarbonate since this increases the rapidity of absorption of salicylate.[10] In methyl salicylate poisoning, it has been repeatedly stressed that a large volume of fluid be used during the lavage (at least one or two liters) until all trace of oily substance and wintergreen odor are removed. To combat the dehydration from sweating, vomiting, and initial increased urine output, 5 per cent glucose in water is started intravenously (the added carbohydrate helps prevent ketosis and has been shown to increase the survival time in animals). Oxygen may be given for possible cerebral anoxia, vitamin K_1 or ascorbic acid for the bleeding tendency (a milligram of K_1 approximately overcomes the effect of a Gram of salicylate), and plasma, albumin, or whole blood for shock. Barbiturates or paraldehyde greatly augment the depressant effect of salicylates in animals, and morphine caused convulsions in poisoned dogs.[10] Therefore depressant drugs should be avoided. Laboratory work to determine acid-base balance should be done frequently.

Respiratory Alkalosis:[18] The alkalosis seen in the early stages of severe toxicity or when a non-lethal dose has been taken is not serious and need not be treated unless alkalotic tetany occurs. The latter will respond to intravenous calcium gluconate or to cautious 2 to 5 per cent carbon dioxide inhalations.

Metabolic Acidosis:[6,19] Arterial or whole blood is drawn for determination of pH, carbon dioxide content and hematocrit (or hemoglobin). Using the normogram of Singer and Hastings,[19] the total buffer base of the patient's blood is then determined and compared with the normal. Using 1/5 to 1/3 body weight (to avoid overtreatment with alkali) the total buffer base deficit is determined and is replaced with intravenous administration of 1/6 molar sodium lactate (or sodium bicarbonate). Replacement therapy with alkali is given as frequently as every 2 or 3 hours as indicated, until recovery becomes evident.

Where there is no pH meter, every attempt should be made to obtain one. Failing this, carbon dioxide combining powers may be used only as very rough guides, clinical judgment being paramount. In milder cases overtreatment with alkali is a danger depending on carbon dioxide combining power alone. Markedly low values suggest the need for replacement alkali. Where laboratory facilities are inadequate, it is suggested that exchange transfusions be given without delay whenever the dose of the poison has been large (especially in small children) or when the clinical course is unsatisfactory.

Recent reports[20,21] of two cases of methyl salicylate intoxication indicate that in infants exchange transfusion is preferable, and a more satisfactory form of treatment. In a serious case in an infant it should be used without hesitation.

The artificial kidney technic would seem to be the ideal method in serious cases. It has been successfully used[22] in salicylate poisoning.

SUMMARY

Poisoning by methyl salicylate (oil of wintergreen) has been reviewed. Its toxic effect is due to salicylate *per se*; but poisoning with oil of wintergreen is more serious than with other salicylates because of the high concentration of salicylate in this oil. As little as a teaspoonful may be fatal. Methyl salicylate is absorbed slowly from the intestinal tract. Peak plasma concentrations occur many hours later, while excretion is delayed two or three days. The mortality of the 96 case reports in the literature is over 40 per cent. *Vital Statistics of the United States* reported that 62 per cent of 520 salicylate mortalities between 1933 and 1943 were due to methyl salicylate. Oil of

wintergreen has a pleasant taste and for this reason is particularly likely to be taken for candy by children. The symptoms are those of any salicylate poisoning.

A case report with fatality is presented. There was a primary respiratory alkalosis due to central nervous system stimulation, leading to renal compensation with loss of some buffer base, followed by a metabolic acidosis due to the action of salicylate at the cellular level.

These combined effects make it difficult to diagnose the status of the acid-base balance during the course of the illness. Available methods for estimating the acid-base balance in such cases are reviewed and a method of treatment outlined. Treatment consists of gastric lavage, intravenous glucose and water, vitamin K_1, oxygen, and treatment for shock if it supervenes. In addition, alkalotic tetany is treated with calcium gluconate intravenously or small doses of carbon dioxide inhalation. Acidosis is treated by replacement of alkali deficiency. In seriously ill infants, exchange transfusion seems to be a good method of treatment. In all serious cases an artificial kidney is the treatment of choice.

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A bibliographic list of 23 citations appears in Dr. Burt's reprints.

Wisdom for the Sterile Couple

Fagan, in the October 1958 issue of the Western Journal of Surgery and Obstetrics, writes that "Infertile couples are often so conscious of trying to make a baby that they sometimes forget to make love. Sexual relations should be a mutually endearing expression of deep love, affection, and respect for each other, and not a cold, calculated affair to make a baby. Babies should happen willy-nilly, conceived in mutual love, not with the planned outline that goes into the manufacture of an intercontinental ballistic missle."

Precipitation of Goldblatt Kidney

While a man of 59 was being operated on for an aneurysm of the aorta, the right renal artery was inadvertently incised. The incision was immediately repaired. In the next few days, however, the man developed a severe hypertension, reaching 250/176 on the fourth postoperative day. The hypertension was resistant to treatment with hypotensive drugs and became associated with pulmonary edema, myocardial infarction and impairment of renal function. When intravenous pyelograms showed that the right kidney was functionless, it was removed. The blood pressure then fell to 120/72 and afterwards remained at normal levels.*

Pathologic examination of the removed kidney revealed that the artery was solidly thrombosed. It also showed large areas of ischemic necrosis involving all parenchymatous elements. The concentration of renin in this kidney appeared to be 34 times the normal. It is concluded that this case is a direct counterpart of the well-known "Goldblatt kidney."

*R. T. MacDonald *et al.* in Circulation, 18:71 (1958).

Miles E. Drake, M.D., Ph.D.

Vineland

Meprobamate in Mentally Retarded Cerebral Palsy*

Although widely hailed as a combined sedative and muscle relaxant, meprobamate was found to be ineffective in controlling spasticity in mentally retarded, spastic children and young adults. And instead of enjoying a tranquilizing effect, many of the subjects showed more destructiveness and irritability while on meprobamate than when free of the drug.

As physicians, we are accustomed to the enthusiastic claims made by service representatives of pharmaceutical houses. It is rarely possible to check such assertions. Here, however, is the report of a test made of the claims for meprobamate. It was asserted that this is a reliable and potent drug in the control of spasticity and excessive motor activity. It is said that meprobamate can do this without decreasing normal tone or volitional movement. These pharmacologic properties[1] seemed worth investigating.

Meprobamate, tradenamed as Equanil® or Miltown® is a synthetic derivative of mephenesin. It is 2 methyl-2n propyl-1,3-propanediol dicarbamate. The drug appears to have a selective action on the thalamus with a secondary tranquilizing effect.[2] It has a primary muscle relaxant action similar to mephenesin but of greater potency and longer duration. This action did not involve the diaphragm but appeared to influence striated skeletal muscles. Electromyographic studies supported the muscle relaxant action.

The study group was composed of 73 spastic mentally retarded females from the population of the Vineland State School. The criteria established were:

1. The diagnosis was established by the medical staff and the psychological staff.
2. Mentally retarded as shown by psychologic evaluation.
3. Frequent appraisal examinations by the author.
4. Observations by the attendants.
5. The assurance that the medication was administered as directed.

The distribution in terms of diagnosis, severity, sex and age are shown in Table 1.

The descriptive term "mild" designates patients who are ambulatory. "Severe" identified a non-ambulatory patient who required complete assistance in self-care.

TABLE 1.

	Congenital Cereb. Spast.	Generalized Spasticity†	Total
Mild	0	10	10
Moderate	15	16	31
Severe	20	12	32
Age 5 through 9	15	15	30
Age 10 through 20	10	13	23
Age 21 through 30	10	10	20

All patients were female.
†Includes birth injury spasticities.

*This work is from the State School at Vineland, N. J., where Dr. Drake is Clinical Director.

1. Berger, F. M.: Journal of Pharmacology and Experimental Therapeutics, 112:413 (April 1954).
2. Hendley, C. D.: Proceedings of the Society of Experimental Biology and Medicine, 87:608 (June 1954).

METHOD

All the patients studied were inmates in a school for the mentally retarded who were assigned to cottages within the institution. Before instituting therapy, each patient was meticulously evaluated by the author. The psychological reports were carefully studied. The profile of achievement in many different areas was established for each patient. This included level of accomplishment in standing, walking, feeding, speech, dressing, toilet habits and social exchange. Many handwriting specimens were studied.

Similar evaluations were made at monthly intervals during the four month study. Observations by the attendants, teachers, nurses and psychologist were solicited and recorded. The drug was administered in doses of 20 to 55 milligrams per kilogram for four months. There was no change in institutional routine other than administration of the drug.

RESULTS

Results are shown in Table 2. Fifteen of the 73 patients reported marked initial benefit from the medication. Ten of these were congenital cerebral spastics and five were spastic birth injuries. There were no objective findings to support this reported benefit. Furthermore, this subjective improvement was fleeting. Only three patients at the end of six weeks of treatment reported feeling better. At the end of four months, these three patients were given an orange placebo for an additional six weeks. They then reported that they felt even better than when on the first drug. The remaining 58 patients experienced no subjective improvement.

Doses in excess of 40 milligrams per kilogram produced rather marked drowsiness.

Seventeen patients had unfavorable side reactions. Sixteen of the seventeen were in the 5 to 20 year age group. These side reactions included excessive drowsiness, increased salivation, marked changes in their patterns of behavior characterized by open hostility, aggressiveness, irritability and destructiveness.

In the seventeen patients who had untoward reactions, there were nine in the "severely"; six in the "moderately"; and two in the "mildly" involved groups. Sixteen of the seventeen occurred in younger age groups. See Table 2.

Since completing this work the published observations of Charash, *et al.*[3] are in accord with the findings observed on this project.

CONCLUSIONS AND SUMMARY

1. Meprobamate was administered to 73 patients with cerebral palsy. None showed objective evidence of muscle relaxation.

2. A third of the patients in the congenital cerebral spastic group showed untoward reactions. This was also true of 13 per cent of these in the birth-injured group.

3. When the drug was discontinued there was no evidence of withdrawal symptoms.

3. Charash, L. I. and Cooper, W.: *Pediatrics*, 21:605 (April 1958).

TABLE 2.

Diagnosis	Number of Patients	Early Apparent Improvement	Extended Improvement		Unchanged	Unfavorable Side Reactions
			Subjective	Objective		
Cong. Cereb. Spastic	35	10	3	0	32	12
Spastic (Birth Inj.)	38	5	0	0	33	5
Degree						
Mild	10	7	0	0	10	2
Moderate	31	5	2	0	29	6
Severe	32	3	1	0	31	9
Age						
5- 9	30	3	0	0	30	9
10-20	23	5	1	0	22	7
21-30	20	7	2	0	18	1

Alvin A. Rosenberg, M.D.

Morristown

Arrhythmias in Acute Myocardial Infarction

Here is a handy little monograph on disturbances of rhythm in acute myocardial infarction—with a usable inventory of helpful drugs. Also stressed is the usefulness of electrocardiographic control of treatment.

Only those disturbances of rhythm which occur frequently in acute myocardial infarction and are important to correct will be discussed here. These arrhythmias often present themselves as grave emergencies. It is important to know that a minor disturbance may herald the approach of a major one. Intelligent treatment of a serious arrhythmia may be life saving.

Whenever possible, obtain positive electrocardiographic evidence as to the type of disturbance. When in doubt as to the diagnosis of a tachycardia or when an electrocardiogram is not available, the safest drug to use, if one must be chosen, is quinidine[1] or procaine amide. These are well established therapeutic measures for all of the tachycardias, and, if ineffective, most of the drug is excreted within 24 hours and another drug may be tried. Most urgent cardiac arrhythmias can be managed successfully by proper use of sedation, digitalis glycosides, quinidine, procaine, amide, and carotid sinus massage.

The clinical severity of any arrhythmia is usually proportional to the disturbance of ventricular rate, whether too rapidly or too slowly. Consequently, the goal of treatment should always be to control the ventricular rate, even though the arrhythmia persists.

VENTRICULAR PREMATURE CONTRACTIONS

Too many premature contractions interfere with proper ventricular filling causing a decrease in cardiac output, and, hence, decreased coronary artery filling; also, they may instigate or herald a serious disturbance of rhythm, ventricular tachycardia. If the premature contractions are due to excessive digitalis, it suffices to discontinue the digitalis for a few days until the rhythm again becomes regular. When the premature contractions are due to a weakened, irritable myocardium with some evidence of heart failure, it is wise to digitalize the patient, and often the premature contractions will disappear. When the contractions are due primarily to myocardial irritability, prescribe quinidine sulfate 0.2 Gram four times daily[1] or procaine amide 250 milligrams four times daily[2] and increase the dose if this is inadequate.

It is important to decrease the myocardial irritability to prevent ventricular tachycardia with its poor prognosis.

1. Gold, H: Quinidine in Disorders of the Heart. New York, Paul B. Hoeber, Inc. (1950).
2. Kayden, H. J., Steele, J. M., Mark, L. C. and Brodie, B. B.: The Use of Procaine Amide in Cardiac Arrhythmias. Circulation, 4:13 (1951).

THIS serious disturbance of rhythm must be treated vigorously and at the earliest possible moment. Morphine ¼ grain, is first injected intravenously. This is valuable when the patient is apprehensive. It also has a favorable effect on the arrhythmia. Sedatives not only calm the patient, but also appear to exert an anti-arrhythmic effect on the heart; thus in many instances the arrhythmia stops soon after the sedative is given.

If the tachycardia is due to toxic doses of digitalis, the drug must be stopped and the arrhythmia treated as from any other cause. If the tachycardia is *not* due to digitalis, and the patient is in congestive heart failure, digitalis may be given without fear of ill effect.[3]

The basic treatment of ventricular tachycardia depends upon the use of quinidine or procaine amide. First, a direct-writing electrocardiograph machine is left attached to the patient. Frequent tracings are taken, especially just before another dose of the drug is to be administered. Quinidine is given orally 0.4 to 0.6 Gram every 2 hours until reversion to normal rhythm occurs, the ventricular rate is reduced to 100 beats per minute, or until signs of toxicity occur, such as QRS widened by more than 50 per cent, ventricular standstill, or ventricular fibrillation. Larger doses of quinidine may be necessary before successful reversion is attained, but a dose of one Gram every 2 hours should not be exceeded, even if toxic symptoms have not occurred. Procaine amide may be prescribed instead with an initial oral dose of 1.25 Grams followed by 0.75 Gram in one hour. Further doses of 0.5 to 1.0 Gram every 2 to 4 hours are given as required.[1] When the patient is unable to tolerate oral medication or the situation is grave, parenteral administration is mandatory: quinidine lactate 0.65 Gram, or procaine amide 1 to 2 Grams initially and one Gram subsequently, may be given intramuscularly every two hours.

IT USED to be said that intravenous injection of quinidine was advisable only in emergencies. We now know that it can be carried out with relative safety by means of the following procedure: 0.65 Gram of the lactate is diluted in 50 to 150 cubic centimeters of 5 per cent glucose and introduced into the vein by the drip method at a rate of 2 milliliters per minute. Electrocardiograms should be taken throughout the injection. This method is safer than intramuscular injections because use of the drug may be discontinued when normal rhythm is restored, or when toxic reactions appear.[3] However, I prefer procaine amide for intravenous use, since it is safer and possibly more effective. It is given at a rate of 100 milligrams every 2 minutes up to a total dose of one Gram, stopping when the rhythm reverts to normal, when the rate reaches 100 beats per minute, or toxic effects appear on the electrocardiogram. The blood pressure must be taken before each 100 milligram increment is injected, since hypotension of severe degree may occur.

Sometimes combinations or alternation of quinidine, procaine amide, and other drugs are necessary. A patient of mine, treated for ventricular tachycardia with procaine amide intravenously was in shock, congestive heart failure, and apparently moribund. The arrhythmia did not terminate after one Gram of procaine amide was injected intravenously, but did stop after 0.4 Gram of quinidine was given orally in addition, and further recovery was uneventful. Another patient was given quinidine orally and procaine amide intravenously on several successive days, but the tachycardia did not terminate until the procaine amide was given orally. Still another patient had a tachycardia easily stopped on two separate occasions by oral quinidine.

Magnesium sulfate is often tried when quinidine and/or procaine amide fail. Ten cubic centimeters of a 20 per cent solution are given intravenously, though mostly without success in my experience. Quinacrine* 400 milligrams

3. Gilson, J. S. and Schemm, F. R.: The Use of Digitalis in Spite of the Presence of Ventricular Tachycardia. *Circulation*, 2:278 (1950).

*Available under the Winthrop-Stearns tradename of Atabrine®.

every two hours, has been used successfully in terminating ventricular tachycardia.[4]

When shock is present as a result of ventricular tachycardia, norepinephrine should be given by intravenous infusion in the usual manner and in a dosage sufficient[5] to raise the blood pressure to 100. This procedure alone may terminate the arrhythmia, but the other measure described above should be used also.

COMPLETE HEART BLOCK

HIGH grade A-V heart block occurs early during acute infarction. It is usually transitory and non-recurrent. As a rule the ventricular rate is high enough (over 24 beats per minute) to maintain an adequate circulation and treatment is not necessary. However, if Stokes-Adams seizures due to sudden failure of the idioventricular pacemaker and asystole occur, 0.5 milliliter of a 1-to-1000 solution of epinephrine may be injected intramuscularly, or directly into the heart, though this may precipitate ventricular fibrillation. Because of this danger, Sherf[6] prefers caffeine to epinephrine intracardially. The epinephrine should be repeated if the attack recurs, but it is better to try to prevent further seizures by giving ephedrine, 25 milligrams or more if necessary, three to five times daily; or epinephrine, 1-to-1000 in oil intramuscularly every 12 to 24 hours. Aminophylline suppositories appear to have some merit in all forms of heart block and 500 milligrams may be given in this form every eight hours. Attacks may be prevented by isopropylarterenol (Isuprel®) hydrochloride in doses of 10 to 15 milligrams sublingually.[6]

Stokes-Adams seizures may occur when a partial A-V block changes paroxysmally to a complete one, and Sherf[5] recommends that the establishment of complete block by digitalis be attempted. However, if the complete block is believed due to excessive digitalis (or if digitalis is a contributory factor) this drug should be withdrawn.

Since these seizures may be due to other arrhythmias interfering with cardiac output, an electrocardiogram should be taken and the administration of drugs postponed until the mechanism of the attacks has been determined with the aid of the electrocardiogram. Some attacks are due to transitory ventricular tachycardia or fibrillation. This should be treated with quinidine or procaine amide rather than epinephrine. Digitalis, if contributory to this type of arrhythmia, should be withdrawn. It is not unusual for a patient to exhibit one mechanism at one time and the other at another time, or even ventricular standstill and tachycardia in rapid succession. Quinidine is dangerous in ventricular fibrillation associated with complete A-V block, and most unfortunate experiences reported in the literature have occurred in patients with A-V block treated with quinidine. However, if the seizures are due to transitory ventricular fibrillation without A-V block, intravenous quinidine or procaine amide is the drug of choice.

Prinzmetal[7] has described the successful use of corticotropin (ACTH) in cardiac arrest when routine drugs proved ineffective. On two occasions, heart block that had been present constantly for several days and that did not respond to the usual treatment, disappeared promptly after administration of corticotropin. Evidently the A-V node and bundle of His had been edematous and inflamed during the acute stage of infarction. This acute condition that caused the block was suppressed by corticotropin. If the block is due to permanent pathological changes, of course, corticotropin will be of no avail.

WHEN ventricular standstill occurs, the best treatment is mechanical stimulation of the heart by punching the chest vigorously with the fist. The mechanical stimulation of the intracardiac needle often suffices to awaken

4. Master, A. M., Jaffee, H. L. and Moser, M.: The Arrhythmias, Cardiac Emergencies and Heart Failure: Prevention and Treatment. Philadelphia, Lea & Febiger (1952).

5. Rosenberg, Alvin A.: The Treatment of Shock in Acute Myocardial Infarction. J. Med. Soc. of N. J., 53:138 (1956).

6. Sherf, D.: Treatment of Cardiac Arrhythmias. *Circulation*, 8:756 (1953).

7. Prinzmetal, M. and Kennamer, R.: Emergency Treatment of Cardiac Arrhythmias. J. A. M. A., 154:1049 (1954).

the automaticity of the ventricles.[6] Cardiac massage has been resorted to successfully in a few reported cases where conditions were suitable for such an heroic measure.

Zoll[8] has developed a new therapeutic approach to the serious problem of Stokes-Adams seizures. This consists of electric stimulation of the heart by means of an externally-applied cardiac pacemaker which terminates ventricular standstill and maintains a regular externally-paced ventricular beat until an adequate, spontaneous rhythm reappears. This apparatus is now available in many hospitals, often through the generosity of local Heart Associations.

Bellet, Wasserman, and Brody[9] have reported excellent results in treating "cardiac arrest, ventricular standstill during Stokes-Adams seizures, the slow idioventricular rhythm of complete A-V heart block, the slow ventricular rates of partial A-V heart block and sinus bradycardia by the administration of molar and half molar sodium lactate solution" intravenously, and even intracardially. Sodium lactate appears to have marked qualities of increasing cardiac rhythmicity while possessing little or no pressor action. However, Zoll, *et al.*[10] in studying Stokes-Adams disease found sodium lactate to be less effective in arousing and accelerating ventricular pacemakers than infusions containing epinephrine or isopropylarterenol (Isuprel®) hydrochloride.

PAROXYSMAL AURICULAR FIBRILLATION

THIS is uncommon in the first 24-hour period following acute infarction, but is frequent thereafter during the acute or convalescent stage. It is often recurrent, but usually only a few hours in duration, and almost always asymptomatic. Therefore, it is felt that a rate of 60 to 100 per minute may be left untreated. When the ventricular rate is rapid and symptoms of heart failure or distressing palpitation occur, treatment should be given by parenteral use of ouabain, Cedilanid®, or Digoxin® intravenously in the usual doses, if rapid digitalization is thought necessary. Digitalis leaf, digitoxin, gitalin, or Digoxin® may be given orally if there is no emergency. When the rate is over 150 beats per minute, or if congestive heart failure is present, the intravenous route should be used. If no slowing has occurred in 24 hours with adequate dosage, an attempt should be made to convert the fibrillation to normal sinus rhythm with quinidine or procaine amide in gradually increasing dosage to obviate toxic effects. As long as the ventricular rate has been slowed, however, conversion is no emergency, unless emboli, uncontrolled by anticoagulants, have been thrown off by the fibrillating auricles.

If failure is not present, and the ventricular rate not too rapid, an attempt to convert to normal sinus rhythm may be made with quinidine or procaine amide after observation for several hours makes it obvious that spontaneous conversion may not occur. If toxic effects set in before conversion has occurred, one has only to wait 24 hours for most of the quinidine or procaine amide to be excreted. Digitalis may then be given to bring the ventricular rate under control. If digitalis had been used first to slow the rate, but unsuccessfully, one might then use quinidine or procaine amide in an attempt at conversion to normal sinus rhythm. It takes much longer to excrete the digitalis and concurrent use of the two drugs has some added danger according to Gold.[1]

Hyperthyroidism, perhaps in a masked form, should be suspected and excluded in every instance of auricular fibrillation. A 60 year old woman under treatment recently for an acute myocardial infarction with congestive heart failure had auricular fibrillation uncontrollable by digitalis and unconvertible because of vomiting and a skin rash due to quinidine. She had been treated with x-ray for hyperthyroidism 20 years ago, and had had no recent

8. Zoll, P. M., Linenthal, A. J. and Norman, L. R.: Treatment of Stokes-Adams Disease by External Electric Stimulation of the Heart. *Circulation*, 9:482 (1954).

9. Bellet, S., Wasserman, F. and Brody, L. I.: Treatment of Cardiac Arrest and Slow Ventricular Rates in Complete A-V Heart Block. *Circulation*, 11:685 (1955).

10. Zoll, P. M., Linenthal, A. J., Gibson, Wm., Paul, M. H. and Norman, L. R.: Intravenous Drug Therapy of Stokes-Adams Disease. *Circulation*, 17:325 (1958).

basal metabolism test. A radio-active iodine uptake study revealed 51 per cent retention in 24 hours by a thyroid gland which was not palpably enlarged, only a nodule at the isthmus being felt on swallowing. It was recommended that radio-active iodine be given for her toxic nodule and that Lugol's solution be given a few days after the treatment in order to more rapidly control the hyperthyroidism.

PAROXYSMAL AURICULAR FLUTTER

SINCE organic heart disease is usually present in patients with auricular flutter, treatment should be directed first towards protection of the ventricular myocardium. If the patient is in shock, the ventricular rate is rapid, or congestive heart failure is present, digitalis is given to convert the flutter to fibrillation and a ventricular rate of 60 to 80 beats per minute. Once the ventricular rate has been slowed, the emergency no longer exists. Conversion to normal sinus rhythm may be then considered if the heart is relatively small and cardiac function is satisfactory. If conversion does not occur spontaneously on discontinuing digitalis, quinidine should be tried. When using quinidine, frequent electrocardiograms should be taken to prevent errors in management since the ventricular rate may increase during treatment, indicating either conversion to normal sinus rhythm or the disappearance of the A-V block usually present in auricular flutter when the flutter rate has been sufficiently lowered to allow the auricular impulses to pass through the A-V node to the ventricle. If one unknowingly increases the dose of quinidine when normal sinus rhythm has already appeared, serious toxic effects may be provoked unnecessarily.

PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA

THIS is treated in the same way as in patients without myocardial infarction. However, in this condition it is more important to terminate the arrhythmia because of its adverse effect on cardiac output and coronary filling, and also because of the increased cardiac work it causes.

The patient should first be adequately sedated and given oxygen, if necessary. Try to end the attack first by carotid pressure or massage except in elderly patients when it may be hazardous. This will stop 25 to 50 per cent of the attacks. The patient is supine with a pillow under the neck and his head turned to one side, the right carotid sinus is located and is quickly and sharply compressed against the underlying cervical vertebrae. Pressure or massage is maintained for 10 to 20 seconds, with the electrocardiograph machine going or with the stethoscope on the apex of the heart. The procedure is discontinued as soon as the tachycardia ceases. If it is unsuccessful, the left carotid sinus is compressed or massaged after a rest period. Bilateral carotid pressure is never advisable, especially in patients with myocardial infarction. Some other method of termination is preferred if repeated unilateral carotid massage is unsuccessful. Other procedures such as induction of nausea and vomiting, the Valsalva maneuver, sudden deep respiration or holding the breath, are all better avoided in a patient with an acute myocardial infarction.

Drug therapy should be limited to digitalis glycosides, procaine amide, or quinidine. Other drugs such as Mecholyl®, Neosynephrine®, apomorphine or epinephrine, should not be used in this often well tolerated condition. Digitalis is the drug of choice, especially if the patient is in congestive failure. If haste is desired, Cedilanid® 0.8 to 1.2 milligrams may be given intravenously followed by increments of 0.4 milligram every 4 hours until the tachycardia is abolished or minor toxic symptoms have occurred. Carotid sinus pressure often will abolish the tachycardia if it is tried soon after the intravenous administration of digitalis, even though it failed before. Maintenance doses of digitalis are then given to prevent recurrence, or if failure is not present, quinidine may be substituted. However, when there is no need for hurried termination of the tachycardia, oral quinidine is the drug of

choice. The first and second doses of quinidine (0.4 Gram) are given one hour apart and are followed by 0.2 Gram to 0.4 Gram every two hours until the attack subsides. Prophylactic doses of 0.2 Gram to 0.4 Gram are given one or more times a day in quantities sufficient to prevent further attacks without the appearance of toxic symptoms.

SUMMARY

1. The disturbances of rhythm important in the treatment of acute myocardial infarction have been discussed and methods for their control have been suggested.

2. The importance of electrocardiographic diagnosis of the arrhythmia, before instituting treatment, is stressed.

29 DeHart Street

Ergotism and Arteriospasm

Ergotism from the ingestion of ergot-alkaloids has become a rare disease in countries which have introduced adequate inspection of grain; but excessive administration of ergotamine tartrate for the relief of migraine or the pruritus associated with icterus has become a source of arteriospastic syndromes.

The liver detoxifies ergot alkaloids. Patients with impaired liver function may build up an increasing concentration of ergotamine when treated with ergot alkaloids. This potential hazard should especially be borne in mind when treating patients with ergot suppositories because ergotamine is absorbed better by the rectal mucosa than that by proximal parts of the digestive tract.

Ergot alkaloids exert their toxic effect mainly on the central and peripheral nervous systems and vascular system. The symptoms are coldness, numbness, Raynaud's phenomenon, intermittent claudication, arteriospastic ischemias, gangrene of a digit or extremity or acute arterial occlusion.*

The following dosage of ergotamine tartrate is recommended as a safe maximum: 1 milligram per week by injection; or 8 milligrams per week in suppository form (four suppositories) or two suppositories per attack, not to be used more than twice a week.

*Fairnairy, John: Medical Clinics of N. A. (1958).

Obstetrical Postmaturity

Eleanor Scott, in the September 1958, Journal of the Women's Medical Association, writes, in abstract:

When a patient comes 2 weeks past her due date how shall she be treated?

She should be studied to see whether she has any placental dysfunction. Does she have toxemia, a contracted pelvis, and fetal malfunction? Cesarean section should be resorted to in uterine inertia rather than oxytocin stimulation, which might cut off more oxygen from an already anoxic fetus. A short period of watchful waiting should be allowed before intervening in postmature uterine inertia or of contracted pelvis, particularly in older primigravidas. Anoxic babies do not stand rugged labors as well as mature ones do.

Routine induction of labor to prevent postmaturity would bring complications. Routine induction would necessarily include a number of patients with long, closed cervices, floating fetal heads, and so forth. Also, whatever unknown facts, hormonal or otherwise, there are that cause the uterus to be late in starting labor seem to operate to cause uterine inertia more frequently when induction is carried out than when labor is spontaneous. A small group of the patients who are past their due date will have evidence of the placental insufficiency syndrome.

Henry A. Connolly, Jr., M.D.*

Summit

A Case of Antihistamine Poisoning

Antihistamines are prescribed freely—sometimes rather casually. Yet as Dr. Connolly reminds us in this brief paper, antihistamines can also pack a kick.

Antihistamine drugs are prescribed freely, and we sometimes forget that, like most potent remedies, these preparations can be poisonous. I present below a case of antihistamine intoxication. The purposes of this paper are:

1. To emphasize the importance of a meticulous history and physical examination with special emphasis on observation and evaluation of the patient's presenting symptoms.
2. To review the pharmacologic action of antihistamines and the indication for using such drugs.
3. To point out the toxic effects of antihistamines and their proper dosage range.
4. To indicate the management of antihistamine poisoning.

A 5½ year old white male mongoloid was recently seen in our emergency room. He was brought into the hospital by his parents because of a flushed face, feverish skin, and alternate states of drowsiness and excitation. The mother said that early in the evening, she had conferred with their physician because of these symptoms. Following examination, he suggested bed rest and a cathartic. However, while driving home from the physician's office, the parents became alarmed about their son's extreme restlessness, and decided to stop at our hospital to have him examined. The child presented the typical appearance of an atropine-like reaction. The mother was carefully questioned about drugs kept at home. There was nothing to suggest any atropine in the house. Further information obtained from the mother indicated that the child had been taking a "green liquid medicine" prescribed by the physician for a cold. A telephone conversation with the pharmacist indicated that this was an antihistamine, chlorprophenpyridamine, commercially available as Chlortrimeton®. The recommended dosage for children of this age is 2 milligrams of the chlorprophenpyridamine or 1 teaspoonful every 3 or 4 hours. Actually this child received 12 milligrams in one dose—about six times the recommended quantity. It seems that the older daughter, wanting to "play nurse" had given the child six teaspoonsful!

The child, on admission, was well nourished and developed but was suffering from ataxia. He was, at this time, hostile toward all persons present, but we were told that he was usually amiable. The salient findings are summarized as follows:

Weight—48 lbs.
Pulse—88 and regular.
Blood pressure—80/50.
Respiration—22 and regular.
Temperature—normal.
Skin—turgor good, hot, dry and flushed color.
Eyes—pupils dilated, non-reactive to light; eyegrounds—dilated blood vessels.
Tongue and lips—dry and cracking.
Throat—slightly injected.
Nose—crusted.
Neck, lungs, heart, abdomen, and extremities—no abnormalities noted.
Central nervous system—hyperactivity of all reflexes.
Urinalysis—negative.
Complete blood count—toxic granulation of the granulocytes.

The child was admitted to the hospital for observation with the diagnosis of antihistamine intoxication. A policy of "watching and waiting" was adopted; and the child was discharged 24 hours later fully recovered without any treatment.

The pharmacologic description of antihistamines is usually given in negative terms by

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discussing the effects of *histamine* and then adding that the effects of antihistamines are conspicuous by their absence. Gilman [1] states that the antihistamines do not produce pharmacologic effects which oppose those of histamine, as does epinephrine. By themselves, antihistamines have little effect on muscular relaxation in the bronchi and gastro-intestinal tract, nor do they markedly influence the vascular bed. On the contrary, the antihistamines act as a blocking agent—just as *atropine* blocks the action of acetylcholine or of the cholinergic nerve impulses. In brief, the antihistamines do not prevent the release of histamine. They prevent the histamine from combining with the receptor mechanism in the tissue cells involved in the characteristic response.

Experimental as well as clinical evidence supports this theory. Antihistamines counteract the effect of acetylcholine in a manner similar to that of atropine. This explains disturbances such as fixed, dilated pupils, flushed face, and hyperthermia, which are sometimes seen in antihistamine intoxication and are almost invariably found in atropine poisoning.

The actions of antihistamines are: (1) to antagonize (to a varying degree) many, but not all, of the pharmacologic actions of histamines; (2) to modify allergic reactions; (3) to modify the anaphylactic mechanisms.

The exact chemical fate of the antihistamines is not clear. It is possible that they succumb to enzymes! Within three to four hours, the antihistamines have been inactivated or completely destroyed.

Antihistamines are used for hay fever, acute coryza, allergies, sea sickness, motion sickness and serum sickness. They are also used as sedatives or hypnotics. The literature dealing with antihistamines, cautions physicians *not* to prescribe these drugs as sedatives or hypnotics, since there are more suitable drugs available for such purposes.

The usual oral dose of antihistamines ranges from 2 to 100 milligrams depending upon the drug used and the age of the patient.

The toxic manifestations of antihistamines may be any one or a combination of the following: dizziness, tinnitus, lassitude, incoordination, fatigue, blurred vision, diplopia, euphoria, "nervousness," insomnia, tremors, nausea, loss of appetite, vomiting, epigastric distress, constipation, diarrhea, dry mouth, dry membranes, dry skin, hyperthermia, flushed appearance, urinary frequency, headache, tight feeling of the chest, heaviness and weakness of the hands, dermatitis, ataxia, leucopenia, and agranulocytosis. Some of these reactions may also be encountered in the therapeutic dosage range.

TREATMENT

TREATMENT of antihistamine intoxication is largely symptomatic. If there is evidence of respiratory distress, an endotracheal tube may be indicated. Artificial respiration may be necessary. Early gastric lavage is desirable, and should be instituted within four hours of the intake of the drug. If indicated, barbiturates should be given for sedation. The short acting barbiturates are preferable—for example sodium thiopental,[2] 30 to 60 milligrams intravenously. Resuscitation and oxygen apparatus should be available at this time.

SUMMARY

A CASE of antihistamine poisoning is presented together with a brief review of the pharmacologic action, the toxicity, usage, and dosage of this drug. Special attention is given to the treatment of antihistamine intoxication.

1. Gilman, Alfred in Goodman, L. S. and Gilman, A.: *Pharmacologic Basis of Therapeutics*. New York 1955, Macmillan. Pages 656 to 659. Edition 2.

2. Commercially available under the Abbott tradename of Pentothal.®

193 Morris Avenue

Special Article • • •

KENNETH E. GARDNER, M.D.

Bloomfield

The Ever-Changing Practice of Medicine

IN AN ever-changing world the practice of medicine and the economic, social and political factors which influence medical costs and the quality of medical care are never static—change is inevitable. The practice of medicine is one of the many pawns on the national chess board. It is caught in the never-ending struggle between the advocates of a socialistic-communistic welfare state with more and more government intervention, control and subsidy, and the advocates of the democratic system of free enterprise with more and more personal initiative, incentive and responsibility.

The American Medical Association is now considering for final action in June its policy on

1. *Free Choice of Physician* and whether this should be considered a fundamental principle without qualification, which is irrefutable, unalterable and incontrovertible as essential to high quality medical care.
2. *Closed Panel Medicine* and whether this concept should be considered detrimental to high quality medical care wherein the free choice of physician is eliminated or restricted.

"THE DOCTOR'S DILEMMA"

THE American physician is now constantly confronted with a reappraisal of the long-cherished traditions of medical practice and must decide where to hold firm and where to yield to change. He must consider carefully whether to maintain or change the fundamental principles of the private practice of medicine with free choice of physician, the fee-for-service principle, and the control of medical policies and medical practice by physicians—and only physicians. He must recognize the economic, social and political trends and their implications on himself as a citizen and a physician, on his patients and the practice of medicine, and on the quality of medical care as it relates to the entire population. He must realize that a decision will eventually be made between a democratic system of free enterprise and the socialistic-communistic welfare state. He must concede that third party participation in the payment of medical costs is well established and he must decide whether to vigorously oppose or accept any attempt by non-medical third party groups to control the policies, standards and quality of medical care, wherein the emphasis is frequently placed on medical costs rather than on quality. This control is accomplished by fixing fees or salaries and a closed panel type of medical care for both patient and physician. He must weigh carefully his decision whether he will accept a reduced fee for low income individuals or families over 65 years of age if he is the only member of the community who is expected to do so. He must continue to cherish the knowledge and to feel justly proud that the private practice of medicine as conducted in the United States has produced the highest quality of medical care in the world, but he must admit that medical costs have greatly increased along with all other living costs during the past ten years. To meet the increasing cost of medi-

cal care he must also be willing to accept prepayment health insurance plans as an established part of our national economy, but he must firmly maintain that payment either in full or in part for professional services shall be paid separately to the physician and not included in hospital or similar costs.

All of the above represent some of the many factors which exert their influence on the current practice of medicine and the economics of medical care. The physician who is indifferent to, or prefers to remain aloof from the economic, social and political trends may suddenly find that the control of the policies, standards and quality of medical care is no longer under the direction and supervision of the medical profession but has passed to the third party non-professional groups which consider cost more important than quality. This will eventually eliminate the two-party patient-physician relationship which places quality above cost.

FIFTY YEARS AGO

THE old order is ever-changing. Let us go back briefly approximately fifty years between 1900 and 1910 and review the standard of living, the practice of medicine and the economics of medical care of that era. The great industrial revolution was well under way and America was becoming the greatest industrial nation in the world.

The *standard of living* was being influenced by our national growth. Although many families still lived on the farm with agriculture a major occupation, the trend was toward the cities and the factories. The industrial work week was sixty or more hours long including Saturdays, with a wage scale between twenty-five and fifty cents an hour. Labor unions were relatively new and were chiefly concerned with better working conditions and shorter hours. They were not political: membership was voluntary: fringe-benefits with health and welfare funds did not exist.

People were thrifty. They accepted their own responsibility to provide for themselves and their families. They owned their own homes, they educated their own children and they saved their own money.

Theodore Roosevelt was President. He was best remembered for his policies on Conservation of National Resources and "trust-busting" to prevent business monopolies. Political philosophies revolved around high or low tariff and nearly everyone was for free enterprise.

The emphasis for national growth was on manufacturing, construction, conservation, and transportation with the railways, shipping, steel and mining among the major industries. The main modes of local transportation were walking, the horse and buggy, and the street car. The automobile was still in its infancy and was popular only for summer excursions. It had many mechanical defects and the motor had to be hand-cranked. Tires were considered excellent if they lasted 5,000 miles. Every car owner was his own mechanic and a kit containing cement and blowout patches was an essential requirement for every trip.

The airplane was a novelty and no one had ever heard of income taxes, social security, radio, television, atomic power, inter-continental missiles, or supermarkets. Central heating, the electric light, hot water heaters and toilet facilities for indoor use were gaining in popularity. The national debt was well under a billion dollars and was considered exorbitant. The motion picture show was the outstanding form of entertainment with two-reel melodramas and the weekly serial extolling the 'Perils of Pauline' was available for an admission cost of five cents on Saturday afternoons.

Houses were large and so were most families. Parents and grandparents were accepted as the responsibility of the family and provided for accordingly. No one received old-age pensions for social security was thirty years in the future. Very few women worked outside the home and then only in positions which were considered "befitting a lady" as dressmaking, bookkeeping, teaching school and music, limited secretarial work and a few positions as sales ladies. Some women worked in factories or performed professionally on the stage but these were not considered to be re-

fined occupations. With few exceptions, "a woman's place was in the home."

MEDICAL PRACTICE: 50 YEARS AGO

THE practice of medicine followed a similar pattern in most communities. Nearly every physician was a family doctor and did general practice. There were only a few specialists outside of the large cities. Many physicians still had a horse and buggy while some of the more adventurous ones purchased automobiles. Surgery was not a routine procedure and was performed chiefly for acute conditions which were usually of an emergency nature wherein the 'patient was rushed to the hospital'! Anesthesia consisted of the open drop method with ether or chloroform. Nearly all babies were born at home. Birth lacerations were generally accepted as inevitable and few were repaired.

Drug therapy was simple according to our present standards. A course of calomel was a common practice and sulphur and molasses frequently served as a spring tonic. Vitamins, enzymes, antibiotics, antihistamines, anticoagulants, and other complicated organic synthetic drugs had to await future developments. Home remedies and patent medicines flourished, aided by the medicine shows which provided entertainment and sold snake oil and herbs suitable for all diseases.

In addition to home deliveries and emergency surgery, the practice of medicine consisted chiefly in the care of the infectious diseases. Cholera, diphtheria, typhoid fever and pneumonia were the great killers of that era. Preventive medicine by means of vaccination, pasteurization of milk, sewage disposal and water purification were just beginning to be accepted as necessary public health measures.

Vaccination was used only for smallpox. Many physicians kept a stock supply of crusts from patients who had previously been successfully vaccinated. A portion of the crust was dissolved in water to make a paste and then scratched into the upper arm of the person to be vaccinated. All vaccinations were covered with a celluloid shield; all became secondarily infected and all left large scars. This was the accepted routine procedure of the day.

The economics of medical care was a secondary consideration. It was considered below the professional dignity of many physicians to send a bill for services. Among those physicians who did send bills it was done infrequently and sometimes only on a yearly basis. In some rural areas where incomes in terms of dollars were very limited, the old barter system was used in exchange for medical care. A physician in these areas might collect only a few hundred dollars a year but his house and barn were filled with all kinds of food, other supplies, affection and gratitude. The fee for service and its method of payment were decided between the patient and the physician. There were no prepayment health insurance plans or welfare funds and the economics of third party participation for the payment of medical care directly to the physician or through closed panel medicine was thirty years away.

A HALF CENTURY OF CHANGE

THUS has been presented a brief review of some of the conditions fifty years ago. As the result of two World Wars and the Great Depression of the 30's, our entire national economic, social, and political structure underwent a rapid and progressive evolution. Rapid changes occurred in our standard of living, the practice of medicine and the economics of medical care.

During the Depression and during the second World War, Franklin Delano Roosevelt was President. Increased emphasis was placed on social legislation. There was more government taxation, spending, intervention, subsidies and control. Prohibition was repealed. The availability of alcoholic beverages changed many of our social habits. Labor unions became more influential. Spiralling wages, along with the increasing cost of liv-

ing changed our former concept of individual responsibility to one of collective security. Prepayment insurance plans for hospital care were developed by Blue Cross and were soon followed by Medical-Surgical Plans for payment to physicians.

The political, social, and economic evolution, in addition to an ever-increasing emphasis on income taxes, corporation taxes, withholding taxes, inheritance taxes and sales taxes, produced other forms of hidden taxation as 'premiums' for a multiplicity of security programs—many under government control or supervision. These additional taxes as 'premiums' cover various kinds of insurance as Workmen's Compensation, Unemployment, Permanent and Total Disability; and, when required by law, extend to personal liability and property damage.

The American physician must be ever aware of increasing taxation whether direct, indirect, or hidden in the form of required 'premiums'—all of which are in addition to the provisions he must make for himself and his family through life insurance, health and accident insurance, fire insurance, and if possible through savings and investment. He must be ever aware that increasing taxation eventually makes the individual more and more dependent upon the government with the ultimate result—that the greater the dependence of the individual upon the government, the closer is the approach to the welfare state.

THE CURRENT LIVING STANDARD

THE old order was ever-changing. The standard of living—and the *cost* of living continued to rise. Working hours became shorter. With the 40-hour and 5-day week there was more time for recreation. Houses were smaller and so were most families. With limited space and higher costs it became more and more difficult to provide rooms and money for dependent parents and grandparents. To provide a regular income for older persons who were no longer self-supporting became a national necessity and thus was developed our present system of Social Security or Old Age and Survivors' Insurance. In addition, many persons had retirement pensions, savings funds, annuities, dividends from investment and property. All of these provided for greater economic security in advancing years and most important of all permitted these older persons to maintain their independence, dignity and self-respect.

There were also many new products developed, especially in automatic household appliances such as electric washing machines, driers, mangles, dish washers, freezers, refrigerators, and frozen foods; electronics produced the radio and television; automobiles improved rapidly and with suburban living there was a need for at least one car in each family and frequently two or three; the jet age, space travel, and atomic power are in the immediate future.

All of these commodities and comforts made life more enjoyable but at an increasing cost. Although the woman in the home was relieved of many household duties, it often became impossible for one income to provide all the family needs and thus the woman in the family—whose 'place was in the home'—became employed in ever-increasing numbers to supplement the family income. With a rapidly expanding economy following World War II, the need for additional employees increased until today about one employee in three is a woman. Deficit financing for governmental expenses and subsidies—which may soon reach 200 billion—was soon duplicated by credit financing and installment buying for individual needs with the inevitable spiral of inflation ever increasing.

THE CURRENT PRACTICE OF MEDICINE

DURING this same period the practice of medicine underwent tremendous changes. Medicine began as an art. It became a science during the past 100 years and is now in danger of becoming an economic commodity rather than an art or science. With the rapid advances in scientific medical knowledge and technics during the past fifty years, it became more and

more difficult for any one physician to be adequately informed on all medical advances in prevention, diagnosis, treatment, convalescence, and rehabilitation in all medical fields, and thus specialization and subspecialization developed.

Fifty years ago nearly every physician practiced general medicine. Today at the last count there were at least fifty-one specialties and subspecialties. Specialization has provided a higher quality of medical care but at an ever-increasing cost.

The impact of specialization on the economics of medical care has resulted in higher medical costs and rightfully so; for the length of time—which may vary from ten to fifteen years after high school; the expense, the ability, and the experience required to train a specialist makes his services more valuable as well as more expensive. This period of training is equivalent to an investment of from $50,000 to $75,000 for each physician and is estimated on no income for this period plus cost of education. However, additional training makes the specialist better able to provide special services and technical skill beyond the usual training and ability of the average general physician.

With a continuing increase in the amount of medical knowledge more and more specialization is inevitable. It will, however, tend to eliminate one of the greatest values in medical care—the general practitioner or family physician. By means of specialization, all preventive, diagnostic, therapeutic and rehabilitation procedures can eventually be included in some specialty or subspecialty category.

CURRENT ECONOMICS OF MEDICINE

The medical profession has always said that the best interests of the patient are served when there is complete cooperation and understanding between the patient and the physician. This applies to the economic arrangement as well as the physical relationship. No third party is necessary to improve the two-party patient-physician relationship. With free choice of physician the patient has already confidently accepted the physician of his choice and is willing to trust him. The quality of medical care the patient receives cannot be measured entirely in dollars but depends upon the willingness of the physician to give of himself through his personal interest and professional integrity.

The entering wedge in the two-party patient-physician relationship has been gradually introduced as an economic factor during the past thirty years through many and various forms of sickness, accident, and hospital insurance plans. Prior to this period the patient bought sickness and accident insurance directly from an insurance company. The physician was not involved and the patient was paid directly by the insurance company. Later a certificate from the patient's physician was required to verify the patient's claim for loss of time due to sickness or accident. The two-party patient-physician relationship, however, was maintained and the patient paid his physician directly for his medical services.

THIRD PARTY PARTICIPATION

With the increase in the general cost of living, and the increasing cost of medical care, many patients were not able to pay large hospital or medical bills out of current incomes and thus fringe benefits for health and welfare and the pre-payment plans for hospitalization and medical-surgical care were born in the 30's. The economics of medical care stimulated the development of pre-payment plans, which include Blue Cross, Blue Shield, the commercial indemnity and major medical plans and the union health and welfare funds. Their growth has been phenomenal and reflects the desire of the greater majority of the people of the United States to have pre-payment insurance for medical and hospital services. A recent survey by The Opinion Research Corporation of Princeton shows that 76 per cent of these same people want free choice of physician. This survey concurs with one of medicine's fundamental principles—the free choice of physician.

The popularity of these pre-payment plans is indicated by the figures which show that in a population of 175,000,000 people, approximately 120,000,000 have some form of pre-payment health insurance. The pre-payment plans and health and welfare funds for hospitalization and medical-surgical care are here to stay and have become an important factor in our medical economy.

With the expansion of pre-payment plans, there has also been introduced third party participation into the payment of medical care. With the introduction of third party participation, the patient now makes his financial arrangements between himself and the insuring plan. In those pre-payment plans where the physician agrees in writing to participate in the plan, payment is made directly to the physician. In those prepayment plans where the physician has no agreement with any plan, he makes his financial arrangements directly with the patient and the plan or the insurance company pays the patient. The financial arrangement, however, should always be between the patient and the physician even though there is third party participation. The physician is bound only to accept plan payment when he desires to do so by voluntary written agreement.

Most pre-payment and health and welfare plans have changed only one phase of the two-party patient-physician relationship—the payment for medical and hospital services—and if properly conducted can be mutually advantageous to all parties concerned. Under this system payment for medical services is assured to the physician without billing the patient. The free choice of physician and the fee-for-service are still retained.

The original purpose of full coverage service benefits was to pay for hospitalization and medical care for the low income groups. This purpose has long since been lost sight of due to the ever-increasing efforts on the part of all plans to increase the number of their subscribers by raising the income level. With increasing third party coverage comes decreasing two-party responsibility. We must carefully consider two alternatives; whether to accept payment in full by the plans or funds, which indirectly encourages the patient to assume no financial responsibility for medical care; or to take concerted action against the full coverage service benefit principle by disapproving fixed fees for service, and consider all fees as indemnity payment except for persons or families with incomes below $3,000 a year. Pre-payment insurance protection could still be offered the subscriber on the basis of a deductible co-insurance principle where the subscriber pays 10 to 20 per cent of his medical expenses after paying an initial deductible amount which may vary from $25 to $100. Full coverage could be applied to hospitalization with indemnity coverage and co-insurance for medical and surgical care either inside or outside the hospital.

Although many plans and funds have been established with the all-inclusive service feature, it is an idealistic but unrealistic approach and invites abuse and misuse. It is no more feasible to try to provide a pre-payment plan to pay in full all medical expenses without some financial participation by the patient than it is to try to provide a pre-payment plan for all food, clothing and shelter on an all-inclusive basis.

Not everyone wants pre-payment insurance. There are still many people (and many physicians) who prefer to make their own terms for medical care. They may have some form of health insurance, but they want to choose their own physician. They want the right to select a doctor who may, or may not, accept plan or fund payment in full. There are many intangible personality factors between the patient and the physician which cannot be estimated in terms of dollars and cents. If it is definitely agreed between the patient and the physician *before* services are rendered that the patient is willing to pay the physician's higher fee, then there can be no misunderstanding and there is no cause for complaint. Difficulties arise when there has been no agreement beforehand and the patient assumes that the physician accepts the patient's plan or fund

payment as payment in full. It is particularly important for the physician to discuss the cost of medical services with the patient *before* services are rendered, especially in those cases where the physician's fees are higher than his colleagues in the same area.

TWO PARTIES . . . OR THREE?

THE big step in third party intervention came when the pre-payment plans in an attempt to provide full benefits promoted the idea of fixed fees for professional services for low income groups. Had this principle of fixed fees for low income groups been maintained the interference in the two-party patient-physician relationship would have been minimal. Next step was to convince physicians to participate under contract with these plans at higher income levels and for the plans to set the fees for medical and surgical procedures in hospitals. This is the basis of our own Medical-Surgical Plan. The patient no longer makes a financial agreement with his physician by direct payment. Because of premiums deducted from wages and other fringe benefits, he assumes that his financial obligations will be paid by the insuring plan. Third party participation is now established when the plan has a contract with the participating physician to accept a fixed fee, and another contract with the patient to pay for his medical-surgical expenses. At this point all financial arrangements are made through the third party and payment is made by the third party to the physician. The economic wedge is now more deeply imbedded and the individual physician no longer sets his own fee.

With the rapid changes in our expanding economy it becomes necessary that all physicians take a realistic look at the practice of medicine as it is affected by the trend of the present socio-economic welfare state political philosophy. We must understand this trend and make every effort to prevent the practice of medicine from being controlled by third parties; whether they be individuals, groups, or government. Only physicians have the knowledge, training, and ability to establish medical policies and costs, to make diagnoses, and to decide upon the type and length of treatment.

With the introduction of third party participation goes the ever-increasing volume of 'paper work.' Confidential information of the two-party patient-physician relationship now becomes public knowledge and since non-professional personnel are not bound by any code of ethics, there is nothing to prevent them from discussing names, diagnoses and treatment.

Third party participation has gradually reduced the moral responsibility of the patient to provide for his own medical necessities. Insurance companies and service plans appear to the average individual as huge organizations with unlimited resources. With the thought that an unlimited amount of funds exists, the average patient who subscribes to a pre-payment plan is inclined to demand more and more services and resents any restrictions either in or out of the hospital even though unlimited service is not included in his contract. Since he no longer pays the physician directly he tends to lose sight of the value of the service rendered. He becomes indifferent to the costs of medical care because of the attitude that the amount of funds available is unlimited. This leads to the demand for overuse and abuse of medical and hospital services. The fact that pre-payment plans can only pay out what they collect in premiums does not seem to occur to many people. They seldom realize that more medical and hospital services can be provided only through higher premiums. The resistance to higher premiums for increased services and the political clamor for investigation of pre-payment plan management shows a lack of appreciation of the fact that more services cost more money.

With increasing third party intervention and control, the next step is to form closed panels in which physicians can be hired and fired, their fees or salaries set, and free choice of physician denied or limited to the patient. Our decision must be—do we want to continue the two-party patient-physician relationship with free choice of physician and fee for service, or will we support regimentation of patients

and physicians into panels with fixed fees or salaries without free choice of physician, and with medical policies established by third parties?

MEDICAL COSTS AND LUXURY PRODUCTS

ALTHOUGH much furor is generated over the cost of medical and hospital care for the purpose of political propaganda and expediency, the total cost of all medical and hospital services is exceeded by each of three non-essential industries; the products of which may indirectly increase the cost of medical care by their excessive use. However, to date there has been no suggestion of a political investigation into the excessive use and high cost of tobacco products, cosmetics and alcoholic beverages or that these three industries should be under governmental control and their products distributed without limit at government expense to the American people as has been advocated for medical and hospital care. The cost of the three major non-essential luxury products is never mentioned as to the inroads they make in the family income even though the average American family spends two to three times more per year for these non-essential products than they do for their total medical and hospital care. For every $100 for medical and hospital care spent by the average family, at least $200 is spent by the same family for tobacco products, cosmetics, and alcoholic beverages.

The general interest in the excessive use of these products is often considered to be purely statistical and scientific rather than economic. Excessive use of tobacco is a recognized cause of coronary artery disease, peptic ulcer, and cancer of the lung; cosmetics have been shown to produce many allergic conditions; and alcoholic beverages are known to produce chronic alcoholism with its associated mental, moral, and economic disintegration along with cirrhosis of the liver. It is one of the fallacies of human behavior to investigate the costs of medical and hospital care but to completely ignore some of the causes which contribute to it.

To point out the dangers of the excessive use or abuse of these products and the fact that the combined cost of these products is two to three times more than the total cost of medical and hospital care is an unpleasant revelation and is soon eliminated by rationalizing it as a bad dream. No one is interested in limiting their luxuries, for where personal pleasure is concerned, health is of secondary importance.

The best treatment of any medical condition is prevention. Where the prevention of infectious diseases and malnutrition is concerned, much interest is manifest. But where prevention requires the elimination or reduction of luxuries and pleasures, interest in prevention quickly diminishes.

AND so the political storm gathers with much oratory and emphasis on the cost of medical and hospital care but with the utter disregard of the fact that the need for more medical and hospital care often results from the excessive use and abuse of the non-essential luxury products—this along with the added economic strain on the family income to purchase these luxury products. It is an indication of immature thinking and lack of personal responsibility and integrity when individuals or families reason that their income can be spent on non-essential luxury products first and that the primary necessities as food, clothing, shelter, and medical care should be furnished by the government. Herein lies the desire for paternalism which is fostered by the advocates of the socialistic-communistic welfare state. It is similar to a child who takes his allowance to buy candy and expects his parents to furnish his milk. This type of immature thinking is acceptable in children but the responsible adult provides for the primary necessities first and then considers the non-essential luxury products.

Under our present democratic system, as long as the average American family can spend two to three times as much each year for non-essential luxury products as for essential medical and hospital care, the actual cost of medical and hospital care is a minor expense in the

family's budget. A reduction of one-third to one-half in the total amount spent for non-essential luxury products would pay for a family's entire medical and hospital expenses. At the same time by reducing the excessive use and abuse of these products, it would improve the general health as well.

SHOULD FEES BE UNIFORM?

IF THE basic principle of free choice of physician and fee-for-service is to continue, the American physician should recognize that fees for similar services must be relatively uniform, and that the highest quality of medical care must be provided at a cost the average citizen can afford to pay. One of the major criticisms of our present system of medical practice is the variable fees charged for the same service by physicians of equal training, ability and experience.

The long cherished tradition that the physician has the right to set his fees according to his own estimate of the value of his services with the approval of his patient may have to be re-evaluated. Years ago many people who were treated free now have some form of prepayment insurance. In the past when only one specialist existed in any field, he could set his fee according to his own estimate of his services.

Today there are many specialists in each field of medicine who can perform all the diagnostic and therapeutic procedures equally well in their respective fields. It therefore becomes increasingly difficult to justify the wide variation in the fees for services charged by different specialists in the same field for a similar preventive, diagnostic, therapeutic, convalescent, or rehabilitation procedure. There are no longer just a few physicians with highly specialized skills. Today there are many well-trained physicians in all specialties and this trend will undoubtedly continue.

If we are to continue to advocate the principle of free choice of physician and fee-for-service, and also to avoid the pitfalls of panel medicine, then we must be willing to agree to the principle of a more uniform fee for similar services. Uniformity of charges will naturally vary from one section of the country to another and may even vary within the same state depending on whether the location is metropolitan, urban, suburban or rural.

PANEL MEDICINE

DUE to the increasing pressure of political expediency, changing social and welfare philosophies, third party intervention and lack of uniformity in fees for similar services, closed panel medicine has gradually developed. These panels are composed of physicians who agree to work for a fixed hourly fee or salary basis. The patient is not permitted free choice of physician or if so on a limited basis only and then within the panel. Medical policies are usually determined and controlled by non-medical personnel.

Closed panel medicine has developed in some metropolitan and industrial areas in an attempt to obtain medical care at lower costs. The emphasis is placed on the cost of medical care rather than on the quality of medical care. High quality medical care is expensive and will continue to be so because the thinking public demands quality. They realize that the time, training, continuous study and cost of a medical education leaves no alternative if we are to continue to train well qualified, competent, and responsible men and women as physicians. They also want the right to choose their own physician and to change physicians if they so desire. They are willing to pay for quality; for without quality medical service reverts to the level of the charlatan and the soothsayer.

Cost is placed above quality and since the panel physician receives a fixed fee or salary the incentive of competition is eliminated. However, since the quality of medical care improves with competition, the quality of medical care must, of necessity, suffer when the incentive of competition no longer exists.

Physicians who are licensed have every right —often from economic necessity— to sell their services in any legitimate way they choose, and in defense of those physicians who are

employed on panels, there is nothing illegal, unethical or immoral about being employed part-time or full-time as a member of a closed or open panel any more than for another physician to be employed part-time or full-time in a private or government hospital, for an insurance company, for a pharmaceutical firm, in a municipal, county, state or federal institution or for the Armed Forces. The chief objection to closed panel medicine is that it denies the patient the free choice of physician, regiments both patient and physician and emphasizes reduced costs rather than quality in medical care. In those areas where there is an insufficient number of private physicians, it is reasonable to concede that a form of closed panel medicine may be the only means of providing medical care.

CLOSED panel services should not be confused with the *open-panel* practice of Blue Shield or Medical-Surgical plans. In these open-panel plans, the physicians agree to accept a fixed fee for service. They thus accept partial regimentation. Medical-Surgical or Blue Shield plans have certain advantages over closed panel medicne. Its medical policies and fees are usually determined by physicians; it permits free choice of physician either within or outside the panel; it provides indemnity payments to participating physicians when the family income is over a fixed amount; it provides indemnity payments to the subscriber when the medical or surgical services are rendered by a non-participating physician.

Closed panel medicine may be desirable for certain groups of individuals and physicians for it represents a form of regimentation. There are always some who think they can do a better job by regimentation; there are always groups of people who lack initiative, incentive and self-reliance who are willing to be regimented; there are other people who think regimented medicine is cheaper; there are some physicians who are not fitted to the competition of private practice and the system of free enterprise and who are willing to be regimented into a closed panel system by the promise of security based on a fixed salary. This type of security, however, may be very fleeting, for closed panel physicians can be hired and fired without cause or reason.

There are some individuals and groups who because they have control of health and welfare funds feel that they can control the practice of medicine by controlling the cost of medical care. Unfortunately there are many people who are forced into closed panel medicine against their will because the organization to which they belong collects from all of them but reserves the right to pay medical costs only for those who select doctors from the closed panel.

Organized medicine should oppose all forms of panel medicine where medical policies, fees, standards and quality of medical care are determined by non-medical personnel. But for those people and physicians who voluntarily choose to be regimented, there should be no opposition to closed panel medicine. The vast majority of the people of this country will readily see the fallacies of closed panel medicine when it is based on cost rather than quality and will undoubtedly prefer to maintain the free choice of physician principle with fee-for-service combined with pre-payment health insurance.

RELATIVE VALUE SCALES

TO COUNTERACT the undesirable regimentation of closed panel medicine, to meet the criticism of lack of uniformity in fees within the medical profession, and to protect the physician from the wide variations in indemnity payments by insurance companies, several state medical societies have recommended the adoption of a Relative Value Scale as a *guide* to establish a rational relationship between professional services. This scale has much merit for it does not set the individual physician's fees but only the unit value or relationship between medical procedures including office and house calls; surgical procedures including assistants and anesthesia; pathology; and radiology.

Since the individual physician determines

his own basic unit value in the four categories listed above, the scale is sufficiently flexible to adjust to the economic variations in all geographical areas, in different communities and even within the same community. For example, if the economic standards of a metropolitan area are twice that of a rural area, then a physician living in the metropolitan area would double his basic unit value. Relative values between all professional services and procedures always remain the same but since the basic unit value is doubled, all relative fees would be doubled.

To illustrate further; if the fee charged by a physician in a given area is $150 for an appendectomy or a relative value of say 30, then a cholecystectomy with a relative value of 50 would cost $250; a subtotal gastric resection with a relative value of 70 would cost $350; or a hemorrhoidectomy with a relative value of 20 would cost $100. These are values in relation to each other.

In the same area or in other areas the fee charged by a physician for an appendectomy may be as low as $100 or as high as $250. In either case the relative value for an appendectomy remains at 30 and all other operations by the same physician would be charged on the basis of their relative value.

These relative values tend to promote uniformity and stability in fee schedules, yet still permit the doctor to set his own unit fee. The plan deserves much further consideration.

ANNUAL COST OF MEDICAL CARE

THE medical profession continues to maintain that the highest quality of medical care is given when there is free choice of physician and that the cost of high quality medical care must be reasonable. Since health is of primary importance to every citizen, what constitutes a reasonable cost for high quality medical care, and how much should a family be expected to pay or budget for annual health services?

Americans today are getting the highest quality of medical care in the world and the most expensive. The increasing cost is due to the discovery of the 'miracle' drugs and the cost of their production; to more and better diagnostic, therapeutic and rehabilitation equipment; to the need for additional skilled personnel to operate this equipment; to the increase in the life span, since elderly people need more medical care; and finally to the spiralling costs of wages, equipment and maintenance.

Approximately ten years ago the average family spent 4 per cent of its annual income for medical care. Today the cost has risen to 5 per cent. In view of the rapid advances in medical care, the quicker recoveries, the shorter periods of disability and loss of work, the decrease in the number of complications from all illnesses and the general improvement in health, the increase of 1 per cent appears to be a reasonable amount.

The family budget today will average 5 per cent of its annual income with a minimum of about $250. This 5 per cent should be adequate to cover the costs of pre-payment health and hospital insurance premiums and to provide for those out of hospital services which are not covered by prepayment insurance. It should be sufficient to cover the deductible and co-insurance type of coverage and it should also be adequate to cover catastrophic illness insurance.

Although all standard living costs have risen 101 per cent in the past ten years (as determined from the U. S. Department of Labor Statistics) the cost of medical care, exclusive of hospital costs, has increased only 87 per cent during the same period. Hospital costs, *which do not include professional services*, rose 300 per cent during the same period due largely to increased wages and the cost of supplies.

Pre-payment health insurance plans have done much to defray the increasing costs of medical care and hospitalization for 120,000,000 people. As medical costs continue to rise, along with all other costs, however, there is increasing agitation by the advocates of the socialistic-communistic welfare state to provide unlimited medical care at government expense. The matter of cost to the government

does not appear to them to be of any great importance.

A medical care program under government control requires the establishment of a large bureaucracy with many clerical employees. In England it was found that it required one government employee for each 100 people, just to keep the records. If the population of the United States is 175,000,000 people on the basis of 1 per 100 the number of employees required would be 1,750,000. If a minimum salary of $3,000 a year were paid, the cost of employees' services, which contribute nothing to medical care, would be $5,250,000,000. This amount must be paid by additional taxation beyond that which must be charged for medical care. Because the cost is hidden in taxes does not make it less expensive. When the additional cost of non-medical personnel is considered it becomes all the more obvious why the medical profession should continue to oppose any form of government control of medical care. If the cost of medical care is already considered to be high, what is to be gained by increasing the cost by 5 billion dollars a year for non-medical personnel?

THE PRICE OF FREEDOM

IN THE ever-changing practice of medicine we must be constantly aware of the changes in the standard of living, the changes in the practice of medicine from general practice to specialization and subspecialization and the impact of the political and sociologic changes on the economics of medical care. Although change is inevitable, not all change is progress. It is our responsibility to see that the highest quality of medical care is maintained and to guide the thinking of our patients—the public—to consider that the quality of medical care is more important than the cost. However, it is also our responsibility to see that the cost of high quality medical care is reasonable. A relatively uniform fee for service is necessary if we are to provide a high quality of medical care and avoid closed panel medicine with its regimentation. Third party participation has become an important factor in our present economy. However, third party participation serves the best interest of the public when it confines itself to the payment of medical expenses and does not attempt to control medical policy.

It is not to be assumed that these are the only problems that confront the practice of medicine or that these recommendations are the only solutions. Change will continue and many of our problems and their solutions will depend upon future political philosophies. If we remain a democratic nation under the system of free enterprise then we will continue to progress under the free choice of physician, fee-for-service, privately financed pre-payment insurance plans and the control of medical policies, standards and ethics within the medical profession. If we become a socialistic-communistic welfare state then we can expect a closed panel system of medicine with regimentation of patient and physician under which a state bureaucracy will dictate by whom, how much, how often and where medical care will be provided. "Eternal vigilance is the price of freedom."

45 Fremont Street

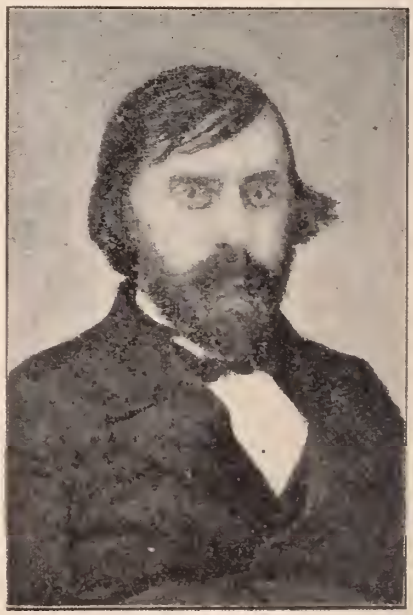
Historical Article • • •

FRED B. ROGERS, M.D.
Trenton

William Augustus Newell (1817-1901): Physician, Governor, Congressman

Most doctors do not realize that New Jersey once had a physician as its Governor. Dr. Newell was probably the only physician to be Governor of two States: New Jersey and Washington. In this brief vignette Dr. Rogers, the Historian of The Medical Society of New Jersey, gives us a colorful picture of Dr. Newell's extraordinary career.

PHYSICIANS today, busy with professional duties, seldom exhibit an active interest in politics. In the past, by contrast, medical doctors were more often elected to public office. A special report, *Doctors in Government*, compiled for the American Medical Association by Dr. Thomas M. Alphin in 1957, listed 359 physicians who, over the years, have served in the United States House of Representatives or Senate. It is a tribute to the medical profession that in every Congress since 1775 there has been at least one physician-member. New Jersey, one of the original 13 colonies, ranks third in the number of doctors supplied to Congress—contributing 30 in all. Perhaps the most valuable of this group was William Augustus Newell, a physician whose medical practice ranged from rural New Jersey to the White House. As a legislator he served three terms in Congress, became Governor of New Jersey and later Governor of the Washington Territory. Also, it was his initiative that led to the establishment of the United States Life-Saving Service, now part of the U. S. Coast Guard, and the U. S. Bureau of Agriculture. A versatile and colorful American, Dr. Newell's life and contributions are worthy of recall.



WILLIAM AUGUSTUS NEWELL, M.D.

William Augustus Newell was born in Franklin, Ohio, on September 5, 1817. His parents, James Hugh and Eliza D. (Hankinson) Newell of Freehold, N. J., had temporarily moved to Ohio but returned to New Jersey when their son was three years old. He was descended from a family known for its medical men. Dr. James Newell (1725-1791) of Freehold, a graduate of the University of Edinburgh in Scotland, had been the sixth president of The Medical Society of New Jersey in 1772, and his son, Dr. Elisha Newell (1755-1799) of Allentown, became its twentieth president in 1795.

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William Newell attended school at New Brunswick, N. J., and was graduated with an A.B. degree from Rutgers College in 1836. He studied medicine at the University of Pennsylvania, receiving his M.D. degree in 1839. His doctoral thesis had as its subject, "Glossitis." Also in 1839, Newell received a master of arts diploma from Rutgers. A medical classmate and lifelong friend was Dr. Thomas Dunn English, New Jersey author, politico and physician.

Dr. Newell began the practice of medicine with an uncle, Dr. Hankinson, at Manahawkin on Barnegat Bay in Ocean County. Newell was examined for license and admitted to membership in The Medical Society of New Jersey at the semi-annual meeting at Morristown on November 22, 1839. After one year's practice, however, he contracted pulmonary tuberculosis with several severe hemorrhages. His uncle sent him to the pine forests of Monmouth County for rest. Here Newell spent life in the out-of-doors, riding horseback and sleeping in an open room for the balsamic, salubrious air. Recovering his health, he settled at Imlaystown in 1842, and two years later he moved to Allentown, where he developed an extensive practice. During the decade after 1842 his name often appeared on the meeting records of the state medical society as a delegate from Monmouth County.

While practicing in Ocean County, the doctor made professional visits along the Atlantic Ocean and Barnegat Bay. He saw the remains of many ships which had been wrecked along the shores of the treacherous New Jersey coast. The morning after a severe storm, at Barnegat City in 1840, Dr. Newell saw the pathetic wreck of an Austrian brig, the *Count Perasto*. Her crew of thirteen floated ashore drowned, although the vessel had been stranded in the surf and the crew members might have been saved by a line from the shore. The dead were buried at Manahawkin in the graveyard of the Baptist Church which adjoined the doctor's residence. Reasoning upon the wreck of the brig, Dr. Newell became enthusiastically interested in the idea of a life-saving plan and service. The cardinal problem was how to throw a lifeline from shore across the surf to a ship in distress. Experiments were first made with bows and arrows and a blunderbuss. Success was finally achieved by the use of a mortar cannon, which interestingly enough, came from the hulk of the *Count Perasto*. Eight years later, when serving in the U. S. Congress, the doctor's plan and apparatus, derived from experience, provided the impetus for the establishment of a Federal life-saving service that was adopted for the entire sea and lake coastline. Indefatigable in this humane cause, Newell in 1848 secured the initial appropriation to establish this life-saving service and later, from 1860 to 1864, served as its superintendent.

Dr. Newell turned his attention to matters political during medical practice in Monmouth County. He was elected to the U. S. House of Representatives as the Whig candidate in 1847, serving in the 30th and 31st Congresses. While in Congress he became physician to former President John Quincy Adams and attended him during his last illness in 1848. The doctor also served as a New Jersey representative at the funeral of our sixth president. After completing two terms in Congress, in 1851, he returned to medical practice in Allentown, N. J.

In 1856 he identified himself with the "American" political party and was elected governor of New Jersey by a majority of only 1000 votes. An event of unusual interest in Newell's life was his memorable walk from Allentown to Trenton for the purpose of being inaugurated as Governor. The inaugural was in January, 1857, when a blizzard blocked the roads, making driving or sleighing impossible. Undaunted by the snow storm, he set out on foot the day before the ceremony and walked the fifteen mile distance alone!

During his governorship, Newell proved to be a vigorous political leader. In a critical period he led the unification of the "American" and Republican parties in New Jersey. After serving two terms as Governor, from 1857 to 1861, the second term as the first Republican incumbent in the office, he was nominated again by the Republicans. The Democrats then named General George B. McClellan as their

candidate. Although his party considered Newell as the only man in the state whose popularity approached that of the famous General, the doctor was defeated by a small majority. He was also defeated on two subsequent occasions, running for Congress.

By 1860 he had become a Republican in politics; in that year he was a delegate to the party's national convention in Chicago. During President Lincoln's administration Newell was appointed superintendent of the Federal life-saving service. Serving from 1861 to 1864, he was mainly responsible for effecting construction of the Delaware Breakwater at Cape Henlopen, off Cape May. Also, for a time he was chief examining physician for drafted soldiers in New Jersey during the Civil War. He served for a period, too, as family physician to President Lincoln, and was a New Jersey representative at his funeral.

In 1865 Dr. Newell returned to Washington, serving as a Republican in the House of Representatives during the 39th Congress. Subsequently defeated for re-election, he nevertheless continued to exert a firm hold on party patronage in New Jersey. In 1871, though a leading candidate for U. S. Senator, he was unable to carry this campaign to a successful result. Again in 1876, he was unsuccessful in an attempt to recapture the governorship of New Jersey.

Dr. Newell became president of the New Jersey State Board of Agriculture in 1875. His efforts while in this office were important in the subsequent establishment of a Federal agricultural bureau. During this interval he was also instrumental in the government's purchasing of Mount Vernon "for agricultural purposes," to preserve George Washington's former estate as a national shrine.

President Hayes, in 1880, appointed Dr. Newell Governor of the Washington Territory. He held this position for four years. From 1884 to 1885 he served as Indian Inspector for the same territory. In these offices, Newell was active in promoting the cause of statehood for Washington. Leaving public office, he returned to medical practice at Olympia for several years. Serving as a city health official, he also was resident physician at the Soldiers and Sailors Home for the State of Washington from 1894 to 1898.

Dr. Newell was married in early life to Joanna Van Deursen of New Brunswick, daughter of Dr. William Van Deursen, a prominent New Jersey physician. Mrs. Newell died while her husband was Territorial Governor of Washington. Two sons, who predeceased their father, were also physicians. One, William A. Newell, Jr., was a medical graduate of the University of Pennsylvania in 1877. A daughter survived the father. Retiring from public life in advanced age, Newell returned to his home at Allentown, N. J., where he died in his eighty-fifth year on August 8, 1901. He was buried with honors in the Presbyterian Churchyard of the town.

Although active in national and state political affairs most of his long life, Dr. Newell never severed his connection with the medical profession. When not in public life, he practiced medicine—in New Jersey, Washington, D. C., or Washington State. A New Jersey medical colleague, Dr. George T. Welch, described Newell as a "stately, dignified figure who gave grace and affable courtesy to medical gatherings . . . he was well versed in medicine and was always an interesting contributor to the scientific meetings of the (Monmouth) county society." From 1857 to 1860, as Governor of New Jersey, Newell was a Trustee of Princeton College. In recognition of his services to state and nation, Rutgers, his *alma mater*, conferred the honorary degree of Doctor of Laws on William Augustus Newell in 1871.

A review of the life and contributions of Dr. William Augustus Newell emphasizes anew the civic and communal responsibilities of the physician-citizen. There is nothing improper or new about a medical doctor taking an active part in government, particularly concerning matters of public health. In the

recent report on *Doctors in Government*, cited earlier, Dr. Thomas M. Alphin states that when the electorate calls, it is a sacred duty on a par with medicine's highest precepts for the physician to contribute to the welfare of his fellow citizens.

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More People See More Doctors Now

Back in 1930, the average American visited a doctor 2½ times a year. The average today is about 5 visits a year.* This is due in part to the fact that more people go to doctors, and in part to an actual increase in frequency of visits by people who always had family doctors. Thus in 1930 only 48 per cent of the people had had any physician-contact in the year—and this included children. Today the figure is 72 per cent. These figures are more dramatic if expressed in the reverse. Thirty years ago, more than 50 per cent of our people went a year with no medical service. Today that ratio is 28 per cent.

The difference between high and low income families has become less noticeable. In 1930, visit frequency was 4.2 for the highest bracket and 2.7 for the lowest. Today the proportion is 5.4 against 4.8. In 1930, 40 per cent of the physician-contacts were in patients' homes. Today the figure is only 8 per cent. Visits in the doctor's office have increased from 50 per cent to 67 per cent of contacts in the last 25 years.

*The statistical data quoted here come from that sprightly brochure *Progress in Health Services* published by the Health Information Foundation of New York. These data are from the October 1958 issue.

Sun Tanning Aid

Psoralen derivatives, chemical substances developed from a plant native to the Mediterranean region, facilitate sun tanning, "both shortening the time required for its production and increasing its intensity and duration," according to Arnold, of Honolulu.*

Probably the chief value of these derivatives, known as 8-MOP and 8-10P, will be found in their ability to increase skin tolerance to sunlight.

This would have two advantages: persons able to acquire a tan could get one and maintain it without inflicting so much permanent damage on the underlying connective tissue. And more importantly, persons unable to tan, and subject to skin cancer, could probably be largely protected against this unpleasant and potentially serious disorder.

*Arnold, H. L., Jr.: Hawaii Medical Journal, 16:391 (March) 1957.

State Activities • • •

Trustees' Meeting

At its February 15 meeting, the Board of Trustees:

—Approved the designation of Dr. Edward Duffy and Dr. Robert Garber to represent our Society before the April hearing of the New Jersey Commission on Mental Health.

—Concurred in the designation of an *ad hoc* committee on medical care programs. The committee includes Drs. Gardner, Bowers, Mccall, Donnelly and Schretzmann together with Mr. Nevin.

—Authorized the editor of the membership directory to designate, by a special symbol, members of the Society for the Relief of Widows and Orphans of Medical Men.

—Granted permission for a spot-check of members on their personal health status as part of the Society's exhibit on heart disease as it related to the physician.

—Instructed the Secretary to write to the Governor protesting against the failure to invite the Medical Society to participate in the planning of the Governor's Conference on Aging.

—Referred to the Committee on Medical Defense and Insurance the problem of cancellation of liability insurance against certain members of the Society and some related long-term questions concerning this type of insurance.

—Requested the editor of THE JOURNAL to give consideration to regular publication of reports on Civil Defense and Disaster Contol.

—Approved the nomination of Dr. Jerome G. Kaufman to the Board of Trustees of Medical-Surgical Plan.

—Received from the Hospital Service Plan an acknowledgment of the Board's action approving the offering by Blue Shield of a contract at a reduced premium to persons 65 and over having modest resources and reduced incomes. The letter stated that the Society, in following so quickly the recommendation of the A.M.A., is to be commended, and can be assured of the fullest cooperation of HSP in implementing the program. The Board was also informed that the matter will be taken up at the next meeting of the Hospital Association's Board of Trustees. The Hospital Association encourages all hospitals to make adequate provisions for the care of this age group, but cannot see how non-profit institutions (which usually operate with sizable deficits) can reduce their rates for an increasing proportion of the hospital population. Since it is unlikely that hospital costs will diminish in the foreseeable future the result of any reduction in rate could only mean incurring a further deficit, thus jeopardizing one of our most essential community facilities.

Hospitalization Survey

The following communication has been received from the State Department of Health, in a letter dated March 19, 1959 over the signature of William J. Harvey, M.D., M.P.H., Assistant State Commissioner of Health.

The U. S. National Health Survey is conducting a methodological study in New Jersey to evaluate the accuracy of hospitalization information obtained from respondents in household interviews. The household interviews will terminate June 27. In the interview, respondents are asked to report on all hospitalizations during the year preceding the interview.

A special follow-up interview will be made on about 20 persons of the households about ten days following the initial household interview. Its purpose is to get at reasons for misreporting in the cases of discrepancy.

All information on individuals, hospitals, or practitioners which is collected in any aspect of the National Health Survey operation is strictly confidential, by order of the Surgeon General. The Bureau of the Census, which does the field work for the National Health Survey, is bound by law to maintain the strictest confidentiality with respect to information it may collect from individuals.

The Hospital Record-Check Study has as its sole purpose an evaluation of how well people can report on hospitalization experience. The study is in no wise a "medical or hospital audit" and does not in any way interfere with the privileged character of medical records in the doctor-patient or hospital-patient relationship.

Programming for Public Mental Hospitals

The State Board of Control of Institutions and Agencies, through Lloyd Wescott, its President, has asked that the following policy statement be published.

In attached letter, Mr. Wescott adds:

"Far too often statements such as this are piously adopted and then forgotten. We have no intention of letting it happen in this case.

"It is obvious that we will not achieve these goals quickly or easily. To achieve them we will need the help of each person working in our mental hospitals; we will need money for salaries and buildings; we will need public support.

"Above all we will need public understanding and acceptance. To many the mentally ill are dangerous persons needing restraint and custody and returning the patient to society often meets with resistance from family and neighbors. The concepts upon which our statement is based are alien to a considerable portion of the population, as you are aware.

"The doctors of the State, because of their own understanding and their unique position in the community, can do a very great deal to help us achieve the acceptances and support we need. If you could bring this to their attention in various ways, we would be most grateful. A similar letter and a copy of the resolution is also being sent to the presidents of component medical societies."

Whereas it is generally accepted that psychiatric disabilities are illnesses in the medical sense of the term, and that the symptomatology shown by a majority of psychiatrically ill patients is not of an aggressive, anti-social, or purposefully self-destructive nature; and

Whereas it is believed that patients suffering from such disorders respond best to treatment given with considerate understanding of the feelings and sentiments of those so afflicted, in an environment which does not of itself alarm the fearful or challenge the uncooperative; and

Whereas the reports of the Medical Directors have pointed to the medical effectiveness of programs in the United States and in Great Britain which give full recognition to these principles: Therefore be it

Resolved, That the State Board of Control affirms as its policy the encouragement in these institutions of programs for the improvement of the physical surroundings in which patients live, and the continued development of practices which insure for all patients the greatest amount of self-determination and personal liberty compatible with their clinical state.

In furtherance of this policy the Director of Mental Health and Hospitals will consult with the Medical Directors of the several hospitals concerned, with a view to the expeditious removal of clinically inappropriate restrictions and the development of physical surroundings more conducive to the patients' mental health.

It is anticipated that the Director of Mental Health and Hospitals and the several Medical Directors will:

1. Study the effects of a materially higher percentage of voluntary admissions on the patient, the hospital and the community.

2. Re-examine our regulations and attitudes toward the easy readmission of patients to hospital.

3. Scrutinize the pre-admission services offered decompensating individuals with a view to facilitating hospitalization when it is necessary and acquainting them with alternative community services when it is not.

4. Assess the nature and extent of the responsibilities given our nursing personnel in order to capitalize as fully as possible on their unrealized potential.

5. Examine our traditional insistence that eradication of pathology is the only proper medical goal and to determine whether an equally important end may not be the social rehabilitation of the patient.

6. Explore the possibility of day care programs for those aged individuals who would otherwise require hospitalization.

7. Determine the extent to which living arrangements for our patients can be improved through assurance of an increased measure of privacy, interior decoration of buildings, reduction in the size of nursing units, rearrangement of beds, development of recreational space and playing fields, replacement of unsatisfactory furniture, and individualization of patients' dress.

8. Work for the reduction in the bed capacities of all our hospitals and to insist on the construction of new institutions if the alternative is the erection of bed containing buildings at existing installations.

9. Examine our whole system of clinical records with a view to retaining whatever is essential and eliminating all that serves no clear purpose.

10. Investigate alternative methods of budgeting which offer promise of simplifying the fiscal administration of our hospitals.

Lymphoma-Leukemia Study

The Medical Society of New Jersey is cooperating with the State Department of Health in a lymphoma-leukemia study. Our Board of Trustees bespeaks your cooperation in reporting cases. For further details, write to Stella Booth, M.D., Cancer Control Program, State Department of Health, Trenton 7, New Jersey. Here is the blueprint:

1. The reporting of all cases of lymphoma-leukemia, diagnosed as such, to the Cancer Program of the State Department of Health through the pathologist who, in the hospital, or private laboratory made the diagnosis.

2. A blood smear and a biopsy wherever possible on the same case of lymphoma-leukemia or other tumors in children under the age of 15. A slide of the blood smear and biopsy for Dr. Booth, Senior Investigator and Coordinator of the Cancer Program of the State. *This should not be sent by mail. It will be personally collected by Dr. Booth.*

3. Permission to abstract the chart of the patient in the hospital or in the doctor's office, in definitively diagnosed cases only; and to confirm other data necessary to complete the questionnaire used in the investigation.

4. The name and address of the doctor referring the patient.

5. The name and address of the patient.

Items 4 and 5 are necessary to complete the interview as this is an epidemiologic study. The interviewer will be a nurse, trained to carry out these interviews.

6. Permission from the physician and the patient to conduct this interview in the home of the patient in order to obtain an environmental history.

Include all cases diagnosed since the first day of 1959. This will not be an excessive burden to any one physician. The estimated number of cases per year in this group of diseases is 92 cases, of lymphoma-leukemia, and 62 other cancers in age groups below 15 years; and among adults the estimated numbers for the entire State are about 800 people with a definitive diagnosis of lymphoma-leukemia (200 - 205 in the International Nomenclature).

We have been specially selected to do this important population study. It will behoove us, therefore, to attempt to collect basic data involving this group of diseases, and thus aid in some way, the scientific study of these entities. This cannot be accomplished without the cooperation of all of the doctors and specialists in the State of New Jersey.

Glaucoma Identification Card

A glaucoma identification card is distributed by the National Medical Foundation for Eye Care as a public service. The address is 250 West 57 Street, New York 19, N. Y.

This card will tell examining physicians and first-aid people that the patient has glaucoma and is using drugs. The names of the patient and of his ophthalmologist appear on the card, together with the prescription. This information alerts the examining physician to the patient's condition and the treatment he is undergoing and forestalls the use of contra-indicated medication.

Glaucoma patients who run out of their prescribed medicine while away from home are able to get a new supply quickly, without interrupting treatment. The card also carries the spectacle prescription of the patient, which enables him to replace broken lenses when away from home.

The National Medical Foundation for Eye Care glaucoma cards were printed as a public service by Abbott Laboratories, and are being initially distributed to physicians by the Laboratories. Packets of the cards may be obtained by writing to the Foundation office, 250 West 57th Street, New York 19, New York.

Education of the general public to the threat of glaucoma and other eye diseases, with emphasis on the importance of regular medical eye care, is a basic purpose of the National Foundation for Eye Care.

Obituaries • • •

DR. WILLIAM H. ARESON

One of Essex County's best known and most beloved physicians died on March 7. Dr. William H. Areson was born in Montclair in 1874. In 1896 he was graduated from Columbia University's College of Physicians and Surgeons. After an internship at St. Joseph Hospital in Paterson he returned to his native city, and thereafter he was to serve the people of West Essex for more than 50 years. During World War I he was in the Navy's medical corps. When the county's isolation hospital was constructed in 1922 he became a member of its Advisory Board, a position he held until his retirement in 1948. For many years he was Health Director of Montclair. He served as President of the Essex County Medical Society. Dr. Areson was proud to be known as a family doctor. He was especially interested in surgery, however, and was a Fellow of the American College of Surgeons.

DR. JOHN W. KINLEY

An untimely death came to Dr. John Kinley on April 12, when he suffered a fatal heart attack at his home. Born in Jersey City in 1902, he received his M.D. from McGill in 1931. He did graduate work at Greystone Park and the Institute for Living in Hartford. He became a board diplomate in psychiatry. At the time of his death, Dr. Kinley was chief of psychiatry and neurology at the Overlook Hospital in Summit. In 1940 he came to Newark and entered private practice of psychiatry and neurology. Later he moved to Summit, and became the psychiatric member of the Summit Medical Group. He was attending psychiatrist at St. Barnabas Hospital in Newark.

DR. EDWIN MACKOWSKY

A life-long resident of Jersey City, Dr. Edwin Mackowsky died at the Medical Center there on March 23 at the early age of 44. A baccalaureate of the University of Maryland, he received his M.D. degree in 1939 at the medical school of the University of Cincinnati. He won a star for foreign service in the medical corps during World War II. He was a member of the Hudson County Medical Society. Dr. Mackowsky was interested in pediatrics, and served as attending pediatrician at the Jersey City Medical Center. He was also on pediatric services at the Christ Hospital and at St. Francis Hospital in Jersey City.

DR. CLARENCE R. O'CROWLEY

The colorful figure of Clarence Rutherford O'Crowley will no longer add zest to the scenes of New Jersey medicine. Dr. O'Crowley died on March 28. A recipient of the Ill award for "extraordinary services as a physician and as a citizen," Dr. O'Crowley also served as president of the American Urologic Society, the Society of Surgeons of N. J., the Essex County Medical Society and the American Association of Genito-Urinary Surgeons.

Dr. O'Crowley was born in Newark in 1879. In 1897 he was graduated from Barringer High School and he joined the Army to serve through the Spanish-American War. On being mustered out, he matriculated at Columbia University and received his M.D. degree from P & S in 1904. He soon interested himself in urology, and became a clinical assistant in that specialty at New York Postgraduate. He served that institution in all grades thereafter. In 1917 he was commissioned in the Medical Corps and was on active duty throughout World War I. He eventually became affiliated in one capacity or another with almost every hospital in Northern New Jersey. He was chief of urology or consultant at most of them. For some time he was chief of staff at Martland Medical Center in Newark. He was also on the faculty of the University of Pennsylvania. Having entered the specialty in 1905, Dr. O'Crowley was generally considered one of the state's pioneer urologic surgeons. He served the people of our state from 1905 until his retirement a half century later.

Civil Defense Items • • •

TRAINING PROGRAM FOR NURSES

In February, Rutgers University College of Nursing held a week-long workshop on the "Role of Nurse in Emergency Childbirth and in Disaster." The program was cosponsored by New Jersey League for Nursing, New Jersey State Department of Health, and The Medical Society of New Jersey.

EMERGENCY HOSPITAL UNITS

The New Jersey State Division of Civil Defense and Disaster Control and the New Jersey State Department of Health have informed us that Office of Civil and Defense Mobilization has authorized the allocation of 85 of the 200-bed mobile emergency hospital units for stockpiling by New Jersey. This unit has all the supplies necessary to set up a complete 200-bed hospital and to keep it in operation for about 10 days. Thirty such units have already been delivered and stored, ranging from one to four hospital units per county. Four additional sites have been approved but the units not yet delivered. Applications for sites for 15 hospital units are pending. This means that sites for storage of 45 of the 85 emergency hospital units allocated have yet to be located. Has any reader any knowledge of a good storage site for a hospital unit that is worth over $32,000 and which will be so essential in disaster? If so, notify your local civil defense director.

PHYSICIANS' PARTICIPATION IN CIVIL DEFENSE

In most municipalities and counties, physicians have *not* taken an active participation in planning of Civil Defense and Disaster Control services or in State and National CPX (Control Center) exercises. This could prove disastrous to the medical care of persons injured in a disaster. If time must be lost, after attack, trying to set up a medical command staff and to make the distribution of physicians and allied personnel equitable, many lives will be lost. Every county medical society should submit names of interested physicians to the county civil defense coordinator or municipal civil defense director for his selection of a county or municipal Medical and Health Director. CPX exercise OPAL 1959 (Operation Alert) was conducted April 17 and 18, 1959.

JOINT BLOOD COUNCIL AND CIVIL DEFENSE

In 1956, the Joint Blood Council was formed by the American Association of Blood Banks, American Hospital Association, American National Red Cross, The American Society of Clinical Pathologists, and American Medical Association. The Joint Blood Council is a nonprofit national organization whose primary objective is "To establish a national blood program in order to assure an adequate supply of blood and blood derivatives to the civilian and military population at all times of peace or emergency and to take all appropriate action in connection therewith."

The Joint Blood Council has just compiled the nation's first comprehensive directory of blood transfusion facilities and services. Copies are available at $1.50 from the Joint Blood Council at 1832 M Street, N. W., Washington, D.C.

The Joint Blood Council is now revising the OCDM Blood Program Manual. The task is to rewrite the Joint Blood Council's "Standards for a Blood Tranfusion Service" so as to develop an acceptable set of minimum requirements consistent with safe blood handling under extreme emergency conditions. The revision has been entrusted to a committee headed by Dr. Walter B. Martin, a member of the American Medical Association's Council on National Defense and also of the Scientific Committee of Joint Blood Council.

TRAINING PROGRAM - WELFARE SERVICES

A one-day training program for Instructors in "Registration and Information Services" of the Welfare Program was held at Rutgers University. This was cosponsored by Middlesex County and New Jersey State Civil Defense organization. Basic objectives in Registration and Information Program, the responsibility of United States Post Office Department and of the Medical and Mortuary Services, were among the topics discussed.

Announcements • • •

Discontinuance of Group Typing of Prenatal Specimens

After July 1, 1959, the State Department of Health laboratories will discontinue the blood grouping and typing of prenatal blood specimens.

For the past five years this activity has been part of a demonstration project under the Department's Maternal and Child Health Program. Federal funds will no longer be available for it. However, there are ample local facilities in over 100 approved laboratories to serve the needs of physicians for these tests.

The statutes still require that prenatal blood specimens be submitted to the State Laboratory or State-approved laboratories for the tests for syphilis as heretofore.

Summer at Saranac

From June 8 to June 26 of this year, you will have an opportunity to get intensive training in diseases of the chest under the auspices of the Trudeau School. This unique graduate course provides outstanding instruction at a tuition of only $100 for a three weeks' session. The faculty includes some of the most distinguished chest specialists in the United States. Half the time is devoted to tuberculosis and half to other diseases of the chest. Enrollment, of course, is limited and it will be on a first-come, first-served basis. The surroundings at Saranac are a summer resort playland for your family while you are studying.

For more details write to the Trudeau School at Box 500, Saranac Lake, New York.

Colpophotography Book

Robert Ganse, M.D., has written a short book on colpophotography and its role in cancer detection. Physicians may obtain a free copy from Exakta Company, 705 Bronx River Road, Bronxville, New York.

N. J. Doctor Wins Book Prize

The China-born, woman gynecologist, Dr. Hazel Lin, of Jersey City, has been named winner of the third prize in the 1958 Pageant Press Best Book Contest, for her novel *The Moon Vow*.

Dr. Lin is a wife and mother, a busy practitioner, and a prolific writer. This is her second novel; her first: *The Physicians*, was published by John Day Co.

Ophthalmology Courses

Starting in September 1959 intensive special courses in ophthalmology will be offered to physicians by the New York Eye and Ear Infirmary. For further details, write to The Registrar, Institute of Ophthalmology, 218 Second Avenue, New York 3, N. Y.

Surgical Tour of Europe

You can take a graduate course in surgery this summer while visiting Russia, France and points in between. For further information, write to Dr. Ross McIntire, 1516 Lake Shore Drive, Chicago 10. Departure is from New York City, by plane on July 24, by ship on July 17. Plane passengers will be back in New Jersey on August 27. Ship passengers arrive in New York harbor on September 2.

Booklet on Stuttering Available

The National Society for Crippled Children and Adults has made available for distribution to the public a booklet on stuttering. Written for parents, it helps them understand stuttering and shows how they may help their children towards better speech. The brochure is obtainable at 25 cents from the National Society for Crippled Children and Adults at 2023 West Ogden Avenue, Chicago 12, Illinois.

County Society Reports • • •

Atlantic

The regular meeting of the *Atlantic County Medical Society* was held on February 13. Dr. Eugene Dalton presided.

The speaker for the evening was Dr. Newlin Fell Paxson, who is the Professor of Obstetrics and Gynecology at Hahnemann Medical College. He was introduced by Dr. Harold Bayer. The subject was "Diseases of the Cervix."

Dr. Bayer thanked the speaker for his excellent pictures and lecture.

The business meeting was opened by having the secretary make an addition to the minutes of the regular meeting held on January 9, 1959. The following paragraph was added:

Dr. Molitch read the following resolution which was seconded and passed:

> "Whereas the Medical Society of Atlantic County is aware of the excellent work carried out by the Guidance Center of Atlantic Area, and, whereas the Society understands the state will not fully support our Center starting in 1960;
>
> We, the Medical Society of Atlantic County, wish to urge the Freeholders to do all that is possible to aid the Center so that it may continue to serve the citizens of Atlantic County;
>
> Be it further resolved that this resolution be sent to the Board of Freeholders, the Guidanee Center, and the Press for publication."

The minutes of the meeting of January 9, 1959 were then approved as amended.

Dr. Molitch moved the acceptance of the application of Dr. Nicholas P. Foris for associate membership. His application has been approved by the Censorship Committee. Dr. Foris was unanimously elected to associate membership.

Dr. Molitch then recommended the acceptance of the promotion of full membership of the associate member, Anthony Chiofalo, M.D. This was also approved unanimously by the Society.

The Public Relations Committee was authorized to investigate the possibilities of: (1) a prize to the highest science student in the senior class of each high school in the county; and (2) a scholarship fund for medical students.

Dr. Donald Davidson discussed the practice of some physicians in "signing out" after certain hours in the evening. They then expected the Emergency Medical Service to care for their patients until the doctors get ready to take calls the following morning. This is not the Emergency Medical Service's responsibility. Dr. Davidson urged that doctors unable to make calls at night make arrangements with colleagues to cover them while they are not available.

Dr. Davidson also discussed "off-shore coverage." There are many physicians there who do not make calls at night. Dr. Marvel offered to have a meeting of those physicians under 45 along the shore area, and perhaps some agreement could be developed for coverage.

The regular meeting of the *Medical Society of Atlantic County* was held on March 13 at the Children's Seashore House. The Vice-President, Louis Rosenberg, conducted the meeting and asked Dr. V. Earl Johnson to introduce the speaker of the evening, Alfred Frobese, M.D., Associate Professor of Surgery, University of Pennsylvania.

The subject for the evening was "Cholangiography in Gall Bladder Disease."

The paper was discussed by Drs. Johnson, Allman, Merendino and Kaman. It was brought out that the cost to the hospital is $35 in the case of the operative cholangiogram and that it was necessary to have the cooperation of the anesthetist, radiologist, and surgeon to get good results.

Dr. Harley, reporting for the Public Relations Committee, wished to thank all who have contributed to the "Capsules of Medicine." He would like to have other doctors contribute articles for publication in the press.

Dr. Harley suggested an award of a fifty dollar bond and a certificate suitable for framing be presented annually to the graduating senior from each of the Atlantic County High Schools, who has taken at least three science courses and who has obtained the highest average for the three subjects, the decision of the school being final. The award winner from each school will be presented at a meeting of the Medical Society of Atlantic County for presentation of the awards. This recommendation was accepted.

Dr. Gleason reported for the Constitution and By-Laws Committee and recommended that our delegates to the State Society be instructed to do all that is possible to assure that all meetings of all committees of The Medical Society of New Jersey be held in Trenton. He also recommended that our delegates be instructed to support the position that the final vote of the membership should be the privilege of the local Society and not the State Society. Dr. Molitch, who has been chairman of the Censorship Committee, believed that a routine for the study of new applicants was desirable. He agreed that the final judgment of the applicant should be the right of the local Society and not the State. Our delegates were so instructed.

The Insurance Committee reported that Dr. Gleason had received 50 favorable answers on the Medical-Surgical Plan. He needs 80 favorable reports before the plan can be activated.

The treasurer's report indicated that 25 mem-

bers had not paid their dues. All members are encouraged to pay their dues or they will be dropped from the county and state Medical Societies.

The secretary read a letter from the Executive Officer of The Medical Society of New Jersey, in which he stated that the State Department of Health had requested approval of a survey to determine the status of poliomyelitis immunization. The Medical Society of New Jersey approves the survey and asks our cooperation. The Executive Committee voted to approve the request.

LEONARD B. ERBER, M.D.

Reporter

Burlington

The Burlington County Hospital has an addition under construction which will add fifty beds to the present capacity. It should be ready before the end of the year.

Dr. Vernon Davis addressed the Medical Society at the March 1959 meeting. He discussed low back pain.

The Society held its April 1959 meeting at Deborah Hospital. The trustees had renamed the institution Deborah Hospital (formerly Deborah Sanatorium) in recognition of the broader field of services now offered. Deborah Hospital has an expansion program under way that will provide sixty more beds and four operating rooms, to take care of the increased demand for patient care.

The scientific program for the April meeting brought three eminent members of the staff of St. Francis Hospital, Trenton, for the evening.

Dr. Ralph N. Cagan discussed the current research in treatment of leukemias. Dr. Howard E. Topley presented a paper on pernicious anemia. Dr. Solomon Weintraub illustrated his discussion with unusual slides of peripheral blood smears and bone marrow preparations depicting the laboratory evidence of several problems of leukemias and anemias.

Four new members entered the Society at the April meeting: Drs. Barlow, Alida Harrington and Robert Rodgers, of Levittown, and Dr. Pauluk of Moorestown.

After forty years of service to the residents of Burlington County the Board of Freeholders closed the Newcomb Chest Hospital in December 1958 in spite of the protests of Burlington County Medical Society. The out-patient service is now installed in the basement of the old Surrogate's office in Mount Holly. The Clinic is being managed by the Burlington County Tuberculosis League. Dr. Paul Klempner of Trenton is the new director and the out-patient services will be continued under his direction. Patients for hospitalization will be sent to state institutions.

RALPH H. VAN METER, M.D.

Reporter

Cumberland

The April meeting of the *Cumberland County Medical Society* was held at Rainbow Lake, Tuesday, April 14, with M. David Baxter, M.D., of Vineland, presiding. There were 35 members present.

At this meeting the annual election of officers was held with the following results: *President*: Benjamin Berkowitz; *Vice-President*: Alfred O. Davies; *Secretary*: Mary Bacon; *Reporter*: Leonard G. Scott; *Treasurer*: Samuel B. Pole, III.

Members of the Executive Committee (1 year): S. T. Day, George H. Huston, 3rd, William S. Fithian, III; *Judicial Committeeman*: Richard Edward Beck, 1964; *Delegates to The Medical Society of New Jersey*: Carl N. Ware, 1962; Sherman Garrison, Jr., 1962; *Alternate Delegates*: Maurice N. Harris, 1962; Benjamin Berkowitz, 1962.

Nominating Delegate: Carl N. Ware; *Alternate*: Mary Bacon.

Members of the Cumberland County Nominating Committee (1 year): Jesse W. Carl, Paul K. Ayars, Ralph S. Phillips.

Brooke Roberts, M.D., Chief of Peripheral Vascular Section at the University of Pennsylvania Hospital, spoke on: "Occlusive Diseases of Peripheral Arteries." The society found Dr. Roberts' talk enlightening as well as interesting.

The meeting adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

The regular monthly meeting was held February 19 at the Woodbury Country Club.

The President, Dr. Thomas Camp, introduced the President of the Gloucester County Bar Association, Mr. Charles Camp Cotton.

The usual business of minutes, reports and communications followed. The application of Dr. Cornelius J. Regan, transferring from Camden County, formerly Chief Anesthetist at The Cooper Hospital, and now at The Underwood Hospital in Woodbury was read, and voted upon favorably.

Dr. Louis Collins spoke concerning the possible nomination of Dr. Sherman Garrison from Cumberland County Medical Society for Second Vice-President of the State Society and its effect on our choice of Dr. A. Guy Campo for that office.

The speaker of the evening was introduced by Mr. Charles C. Cotton. He was Dr. Benjamin F. Boyer, Dean of The Temple University Law School and his topic was: Medico-Legal Aspects of Will and Estate Planning. He emphasized the importance of the physician's part in the decision of mental fitness in making wills, particularly those revised or last-minute changes.

There was also a discussion of the wisdom of incorporating as a local group.

The meeting adjourned at 10:30 p.m. for a collation and an informal question and aswer period.

DOROTHY M. ROGERS, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on March 3. Dr. John J. Bedrick presided.

Guest speaker for the evening was Dr. S. Arthur Localio, Professor of Clinical Surgery, New York University Postgraduate Medical School. The subject of Dr. Localio's presentation was "Ulcerative Colitis." Dr. Louis Perkel participated in a discussion from the floor.

Dr. Jules C. Bigliani of North Bergen and Dr. Norman Lasker of Bayonne were elected to membership.

The *Hudson County Medical Society* held its regular meeting at Jersey City Medical Center on April 7, with Dr. John J. Bedrick presiding.

Guest speaker for the evening was Dr. Joseph Canary, Assistant Professor of Medicine, Georgetown University School of Medicine. The subject of Dr. Canary's presentation was "Management of Practical Problems of the Diabetic Patient." Many members participated in a discussion from the floor.

For membership on the Nominating Committee of the Hudson County Medical Society for 1960 were: Drs. John J. Bedrick, Joseph P. Donnelly, Sigmund Braunstein, Charles E. Rosen and William Gleeson.

CLEMENT M. JONES, M.D.

Reporter

Mercer

A business meeting of the *Mercer County Medical Society*, under the chairmanship of Dr. Samuel J. Lloyd, its president, was held Wednesday evening, April 8.

A letter was reported from Charles H. Calvin, M.D., President, New Jersey Chapter, American Academy of General Practice, together with copy of a resolution concerning "Accreditation of Hospitals, Intern and Resident Training Programs." This was referred to Mercer Society's Delegates to The Medical Society of New Jersey.

The Society concurred in the proposal that a survey be made, under the sponsorship of the New Jersey Department of Health, in cooperation with the local health department, to determine the status of poliomyelitis immunization in Trenton. Also approved was a proposed venereal disease survey to determine the incidence of venereal disease in untreated cases in the City of Trenton.

The society approved a resolution relative to the Special Committee on Rehabilitation of The Medical Society of New Jersey, which recommends publication of a directory of local rehabilitation services.

President Lloyd was empowered to appoint a committee to consult with the hospitals of the county to ascertain which is willing to house a Poison Control Center. The committee will submit recommendations for further consideration.

Drs. Marinus VanWeele and Jack L. Ward were elected to Active membership; and Michaele L. LaPorta and George F. Liebrecht, to Associate membership.

LAWRENCE I. BONIN, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by Dr. George J. Kohut, its president at Roosevelt Hospital, Metuchen, March 18, at 9:00 p.m.

Dr. Maria G. Koroljow of New Brunswick was elected to Regular membership from Associate membership and Dr. Palma E. Formica, Old Bridge, was elected to two years' Associate membership.

Dr. B. F. Slobodien, Chairman of the Medical Liability and Insurance Committee, brought to the attention of the membership that the Society offers a $10,000 term insurance. As soon as 30 per cent of the membership enrolls, it will be possible at a later date to convert this to straight life or endowment insurance.

Dr. William Rubin, Chairman of the Public Relations Committee, read a column from the New Brunswick *Daily News* praising the physicians' work in the East Brunswick poliomyelitis inoculation program. The Board of Education and citizens of that community thanked the physicians for the donation of the fees to the high school library fund

Mr. Oscar Hanigsberg, C.P.A., of the Federal Estate Planning Tax Commission, spoke on "Short Term Trust and Other Tax Saving Vehicles." Mr. Hanigsberg emphasized the fact that doctors were not comparable to businessmen in that doctors make income by their skill and not by property. As such, it is impossible to transfer his income. Income must be diverted into property which is then transferable by means of trust and custodial cares to the immediate family.

DONALD T. AKEY, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held March 17 at 9:00 p.m. at the Passaic City Club. Dr. Julian Cohen, First Vice-President, presided in the absence of Dr. Graham.

The following were elected to Associate membership: Drs. Ivan D. Barchenko, Passaic and Walter K. Shelley, Little Falls.

Dr. Cohen spoke of the campaign on poliomyelitis being organized by Dr. Berkhout, Chairman of the Committee along with Mr. Bentley of the Passaic Chapter of the National Foundation. This program is being set up to immunize as many people as possible in as short a time as possible. In this connection, Dr. Berkhout reported that in February 1957 our Society decided to organize a campaign for poliomyelitis inoculations. This year, it was suggested that the committee be reactivated since there are many more cases than the year before. Dr. Berkhout outlined a program for mass immunization, to be carried on throughout the county in conjunction with the local chapter of the National Foundation. It was suggested that members of the county society again agree to give immunization in their offices at $3.00 per injection.

A motion was adopted re-affirming the action of the Society taken two years ago to further the poliomyelitis immunization campaign. A second motion requesting that the County Society finance a program of mass immunization was *not* approved.

Dr. Cohen then turned the meeting over to Dr. Edward Edlkraut who said this meeting was in memory of a surgeon and member of our Society, the late Dr. Cornelius Vander-Clock, who died July 9, 1951. He was on the surgical staff of the Passaic General Hospital.

Dr. Edlkraut then introduced the guest speaker, Dryden P. Morse, M.D., Director of the Department of Thoracic and Cardiac Surgery, Passaic General Hospital. Dr. Morse spoke on "Newer Advances in Open Heart Surgery." A question period followed.

A sumptuous collation was then served by the Passaic City Club staff.

DAVID B. LEVINE, M.D.
Reporter

Salem

The Elmer Community Hospital was host to the *Salem County Medical Society* at its regular meeting on March 20.

Dr. Charles Gilpatrick presided over a short business meeting at which time Dr. James Stout of Woodstown was accepted for membership into the Society. A proposal was made to have representatives from the lawyers' group of Salem County attend the next meeting to discuss mutual problems. The announcement was made that the annual Shad Dinner will be held on May 16, at the Salem Country Club.

Dr. William A. Jeffers, Associate Professor of Medicine at the University of Pennsylvania Hospital, spoke on the *Treatment of Hypertension*. He reviewed the use of various medications in treatment of high blood pressure over the past several decades with particular emphasis on the untoward side effects encountered.

A summary of treatment outlined the need for patients getting adequate rest especially after meals, appropriate diets, particularly those low in fat and the use of correct drug or combination of drugs for the patient. Dr. Jeffers was sponsored by the Salem County Heart Association as a part of its educational program.

Following the scientific session the members adjourned to the dining room where a delicious turkey dinner was served. Again the hospitality of Elmer Community Hospital left nothing to be desired.

G. F. REICHWEIN, M.D.
Reporter

Pamphlets on Blindness and Eye Care

A wide variety of pamphlets and leaflets (14 of them) on all phases of eye care, including blindness and glaucoma, may be obtained from The Philadelphia Association for the Blind at 100 East Price Street, Philadelphia, Pa. A physician may obtain a sample of the entire collection by writing to the association and then may select specific pamphlets or leaflets for distribution to patients or to organizations. These brochures are also useful to doctors in preparing talks to lay groups on visual aids or eye care.

Mrs. George O. Rowohlt: Auxiliary President

Born Marguerite Ernestine Graulich on April 26, 1912, in Brooklyn, New York, our new State Auxiliary President, Mrs. George O. Rowohlt, of Dumont, received her early education in the public schools of Long Island.

In 1932 she was graduated from The Scudder School, a finishing school for girls located on lower Fifth Avenue, New York City. The next four years were spent being the private secretary to an officer of the Dry Dock Savings Institution. In 1936 she married George Otto Rowohlt, M.D., a graduate of Tufts Medical School and a member of the Bergen County Medical Society. This was the culmination of a romance that started at the age of sixteen.

They have two children: Elizabeth Ann, 21 and George Ernest, 16. Their household also consists of a brown French poodle, Koko; a Siamese cat, Demi Lun Thai; and a silver domestic neuter, Mr. Thomas Cat.

Peg, as she is known to everybody, has been on the State Board continuously since she first joined it as County President in 1954.

Through the years many and varried interests have claimed her attention. She has been very active in the Teaneck Woman's Club, resigning the second vice-presidency to give her full attention to the job of president-elect of the Auxiliary. Her chief hobby is amateur theatricals. She started a dramatic club in Teaneck and served in the capacity of either actress or director for the past ten years.



Her community activities have been many. To name a few: served as secretary on the Board of Governors of Englewood School for Boys; served as a member of the Board of the Bergen County Blood Bank; served as program chairman for two years on the Council for Local Public Health Agencies.

In short, she is the busy wife of a general practitioner.

AMA Auxiliary Convention

Mrs. A. Guy Campo of Westville will represent our New Jersey Auxiliary next month when more than 2,500 physicians' wives gather at Atlantic City's Haddon Hall for the 36th annual convention of the Woman's Auxilary to the American Medical Association. Committee meetings and round table discussions will be held June 6, 7, and 8 with formal opening of the convention slated for Tuesday morning, June 9.

Business sessions on Tuesday and Wednesday presided over by Auxiliary President Mrs. E. Arthur Underwood of Vancouver, Wash., will be devoted to state and national committee reports and discussions on civil defense, mental health, allied medical careers, automobile safety and community service.

One of the highlights of Tuesday's general meeting will be a presentation on survival medicine in national defense by Lt. Colonel Ingalls H. Simmons, director of Preventive Medicine, Fort Sam Houson.

Local convention arrangements are under the direction of Mrs. David B. Allman of Atlantic City, general chairman. One of the outstanding social events of the convention will be the annual tea in honor of the Auxiliary president and president-elect.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Medical Department, United States Army in World War II, Volume IV, Communicable Diseases Transmitted Chiefly Through Respiratory and Alimentary Tracts. Edited by Col. John B. Coates, Jr., MC, USA, Department of the Army, Washington, D. C., 1958, Pp. 544. ($5.50)

This book, the first of three dealing with communicable diseases in the Army during World War II, like other volumes in the preventive medicine series, is a record of how medical officers, civilian experts and other public health authorities joined to effect the most successful military medical campaign that has ever been accomplished.

Opening with a fine introduction by Dr. John E. Gordon of Harvard, this volume covers the preventive medical aspects of (1) diseases caused by viruses, bacteria, and fungi; and (2) diseases transmitted chiefly *via* the alimentary tract, including diarrheas and dysenteries, food poisoning, and bacterial and parasitic infections. The scope of this epidemiologic survey is worldwide.

Twenty-one distinguished contributors have made this an authoritative and comprehensive volume. Important communicable diseases from amebiasis to whooping cough are covered in the 24 chapters of the book. The illustrations, charts, tables and index are well done.

Of obvious importance to medical personnel in the Armed Forces, this book will also be useful to clinicians and public health workers in civilian life. It contains material of value to the sanitarian, public health nurse and industrial physician—and the agencies and organizations in which they work.

This definitive volume is expertly done. It comprises part of the official series which will document military medical accomplishments during World War II.

FRED B. ROGERS, M.D.

Emergency Treatment and Management. By Thomas Flint, M.D. Philadelphia 1958, Saunders. Pp. 539. Ed. 2. ($8.00)

The complete contents, the clear presentation and the flexible binding make this a valuable book in any doctor's bag, book shelf or desk drawer. Dr. Flint lists the emergencies alphabetically which gives the book a somewhat spurious convenience for quick reference. It is handy to have sections running the alphabetical gamut from Abdominal Pain, Abortions and Abrasions to Vertigo, Vincents and Virus. But if you want to find atom bomb injuries in a hurry, you will have to turn to the index. It's listed under "War Time Emergencies." You might look up "bleeding" in a hurry, only to find it under "hemorrhage."

In addition to an outline for the treatment of each emergency, Dr. Flint has provided us with an amazing amount of information on medicolegal safeguards, clerical administration, drug dosage and the like. Also included is a 178-page section on poisons which makes a veritable manual of toxicology in its own right. All told, a valuable, usable *vade mecum* that will often prove to be a friend in need.

VICTOR HUBERMAN, M.D.

Difficult Diagnosis: A Guide to Obscure Illness. H. J. Roberts, M.D. Philadelphia 1958, Saunders. Pp. 913 with 99 illustrations. ($19.00)

Here is an index of signs and symptoms running the alphabetical roster from acetonuria and aches to wheezing and xanthomata. This is a graduate level treatise on differential diagnosis which emphasizes the atypical, the rare, the *formes frustes* manifestations. It includes a unique chapter on iatrogenic illness and a wonderful group of over 5000 selected and classified references. In the first section, diseases are arranged in the conventional pattern—metabolic disorders, liver diseases, infections, and so on. Included is a 65-page atlas of systemic skin syndromes plus a 50-page text chapter on dermal clues to systemic disease.

Other unusual features are a catalogue of tests and diagnostic procedures, a chapter on obscure postoperative complications and one on diagnostic problems related to abdominal pain. While $19 may seem a lot of money to pay for a 900-page volume, it must be remembered that this is really several volumes in one. It is full of shrewd advice and practical pointers on diagnosis.

ULYSSES FRANK, M.D.

Health Statistics. U. S. Public Health Service. Washington, D.C. 1958. Government Printing Office. Pp. 49. ($0.40)

Illness or injury caused the American people to cut down on normal activities for about 3½ billion days during the year ending June 30, 1958. This is reported in the first U. S. National Health Survey publication to provide figures from a full year of nationwide household interviewing.

The report gives selected statistics on acute conditions, chronic conditions, persons injured in accidents, physician visits, dental visits, and disability.

Commenting on this, Dr. Leroy E. Burney, Surgeon General of the Public Health Service, says: "With this first annual summary, the Health Survey is beginning to produce a comprehensive picture that workers in the health fields have long needed."

The importance of chronic conditions is indicated by the fact that circulatory diseases alone were the cause of 484,200,000 days of restricted activity. Circulatory diseases rank higher than any other group of chronic conditions in this respect. However, mental and emotional illnesses are not included.

People visited their physicians 900 million times, or an average of 5¼ times per person. People went to their dentists 269,200,000 times, or 1.6 times per person on the average.

For most of the topics covered, the figures are shown by calendar quarter, pointing up the seasonal differences. Age, sex, and rural-urban residence are also shown in most instances.

This book is Public Health Service Publication No. 584-B5. Copies are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C. It is a solid if unexciting monograph that, if you have the patience to dig it out, provides base data for disease and disability incidence.

ABRAHAM LEFF, M.D.

The Care of the Geriatric Patient. Edited by E. V. Cowdry, Ph.D. St. Louis 1958. Mosby. Pp. 438. ($8.00)

The best chapters of this book deal with the nursing, administrative and social aspects of gerontology. Unfortunately the physician-oriented chapters are generally poorer. This is an anthology by 22 contributors, only 11 of whom are physicians. There is much talking-down to the reader. *Example*: "Reserpine is an old Indian herb which reduces some kinds of hypertension." *Another example*: "Individualization is the essential principle of geriatric surgery." Empty cliches like these abound. The author of the chapter on drugs is enchanted by reserpine. In the first chapter, the editor suggests you should refer to the *Directory of Medical Specialists* to determine "whether a particular internist has been certified as competent." The chapter on anesthesia is a highly practical one. Curiously, there is a 15-page section devoted to genetic factors, and the author of the chapter on medical aspects also emphasizes genetic factors: "inherited diseases that may appear after a certain age."

The text covers nursing homes, social services, hospitalization, geriatric nursing (the most usable material in the book), dental care, geriatric psychiatry, surgery of the aged, psychologic aspects of managing the aged (which paints a dreary picture of the problem), the use of drugs, and an interesting global review called "Geriatrics Around the World."

HENRY A. DAVIDSON, M.D.

The Sedimentation Rate of Human Erythrocytes. By Frank Wright, M.D. New York, 1959, Vantage Press. Pp. 43. ($2.50)

In this brief edition, prophetically faced with an atomic mushroom cloud, Dr. Wright recounts experiences and conclusions drawn from more than twenty years in the study of the sedimentation rate. He explains in terms of viscosity and refractometric index, the significance of this determination as an "energy reaction exchange." Extrapolating this energy concept, he discusses the usefulness of the E.S.R. in evaluating medical problems varying from those of the high pressured executive to that following atomic radiation.

His formulated, individualistic concepts will intrigue many and likewise be a source for future reference. Dr. Wright's efforts are those common to the advanced clinician and research scientist. His edition should have a place in any medical library.

VICTOR IRMIERE, M.D.

The Eternal Search By Richard Mathison. New York 1958. G. Putnam's Sons. Pp. 381. ($5.95)

Richard Mathison, a newspaperman, was browsing in a herb doctor's shop in San Francisco. His imagination was caught by the exotic drugs, herbs and roots that he saw there. This led him into an investigation of the history of pharmacognosy—hence this book. Here are chapters on pain-killers, incense, antisepsis and cannibalism; chapters on purging, puking and aphrodisiacs. Mr. Mathison makes a self-conscious attempt to shock the squeamish. He tells of throwing virgins into fires, of the eating of dog dung, and of other ancient practices that make the tender reader nauseous. He includes something of the pageantry of pharmacy, the history of the condom, the lore of the bedchamber, and the almanac of drugs. The style is lucid, the writing is interesting, the anecdotes are arresting or amusing. He writes of laxative and incense, of enemas and honey, and of other strange bypaths along man's eternal quest for the everlasting pill.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

May, 1959 • Vol. XXXII, No. 4

CHRONIC PULMONARY DISEASES IN PATIENTS WITH LUNG CANCER

An intimate relationship between nonmalignant and malignant pathology in the lungs is suggested by an investigation of the clinical history of a hundred cases of lung cancer.

Pulmonary pathology, such as pneumonia, atelectasis, or tuberculosis, often masks the presence of a lung cancer and creates diagnostic difficulties. The question arises whether such pathologic changes are secondary complications, are merely coexistent, or have preceded the carcinoma. The prevalent view is that usually lung cancer develops in a previously healthy organ, and that in general nonmalignant pathology is due to the new growth or is coincidental.

However, judging from case histories as well as roentgenologic and pathologic findings, chronic lung processes antedate a cancer in many cases. This suggests that an intimate relationship between nonmalignant and malignant pulmonary pathology may exist in the lungs.

Clinical investigations on a possible link between common nonoccupational lung diseases and pulmonary cancer have been few and inconclusive. Still, in some series of patients with lung cancer previous chest ailments were prevalent, and follow-up statistics indicate an increased risk of respiratory cancer in persons with chronic bronchitis. It is commonly reported that many patients with lung cancer have had a long history of chronic cough. Whether this symptom is considered insignificant, or is labeled "smoker's cough," it usually signalizes some respiratory disorder.

These considerations give rise to the clinico-roentgenologic study reported here, which attempted to determine retrospectively the amount of important pre-existing respiratory sickness in a group of patients with lung cancer.

WALTER FINKE, M.D., *New York State Journal of Medicine, December* 1, 1958.

METHODS OF INVESTIGATION

The basic material for this investigation was the records of 100 unselected patients with proved primary lung cancer of any histologic type who had been admitted to The Genesee Hospital during the past 15 years. The routine histories proved to be inadequate so records of previous admissions were reviewed. Additional information was sought from the patients, their families, physicians, and institutions which had knowledge of the case. Only acute respiratory illnesses which had occurred at least ten years prior to the diagnosis of lung cancer were included in the final analysis. Similarly, only chronic pulmonary disorders that had existed at least ten years were considered significant.

A reasonably accurate picture of the previous respiratory status could be reconstructed for 86 of the 100 patients. In addition to this clinical information, a roentgenologic history of 63 of the 86 patients was obtained.

CHRONIC RESPIRATORY DISEASES—Over 90 per cent of the 86 patients whose previous respiratory health could be reinvestigated had had a chronic cough for at least ten years and in most cases for twenty years. As a rule, the cough was productive or if "dry," associated with dyspnea or "asthma."

FREQUENCY OF CHRONIC PULMONARY DISEASE OF TEN YEARS' DURATION OR MORE IN 86 PATIENTS WITH LUNG CANCER

Chronic Respiratory Disease		Number of Cases
Chronic bronchitis (moderate or very severe)		56
with chronic asthma	27	
observed for tuberculosis	29	
Chronic pulmonary tuberculosis		6
Silicosis or sequela to gas poisoning in World War I		3
TOTAL		65

Most of these patients had required frequent medical care for years. Many had been disabled repeatedly, and some had become pulmonary cripples long before the malignant disease supervened. Thus, the illness that proved to be lung cancer often seemed at first an aggravation of an old chest ailment rather than a new and different disease.

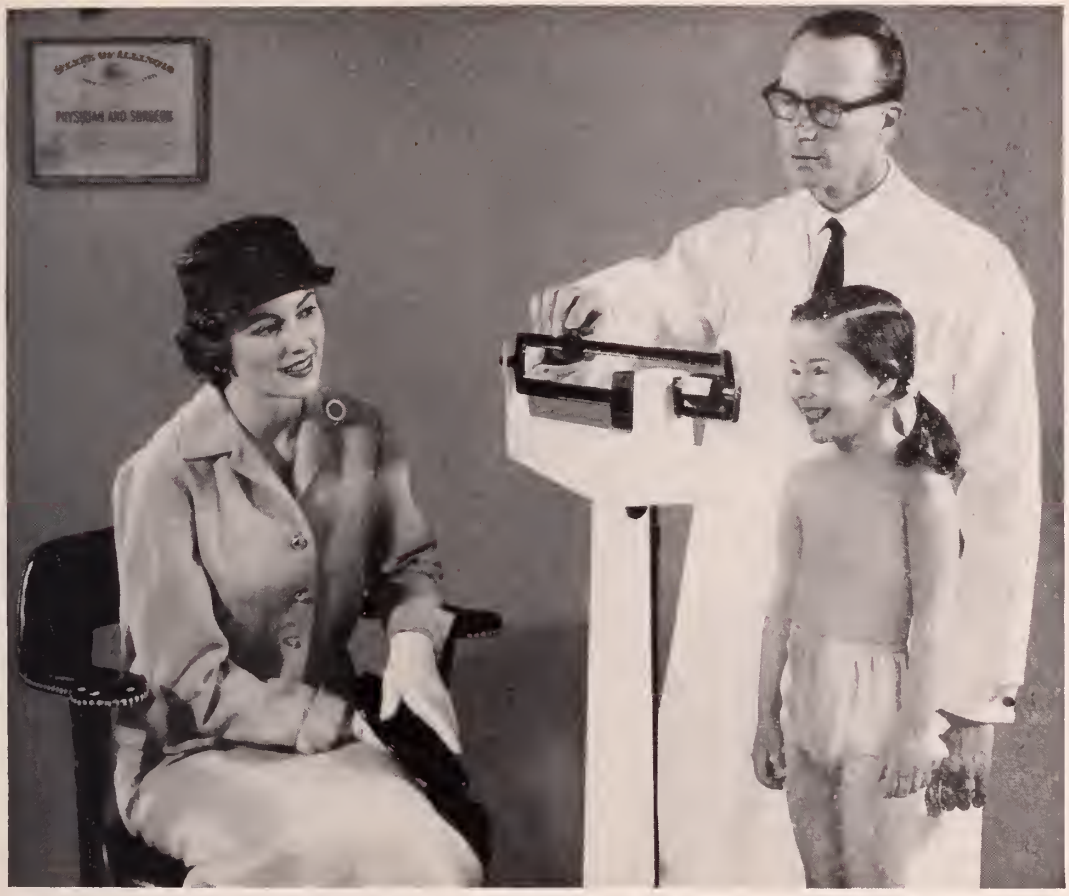
ACUTE RESPIRATORY ILLNESS—A history of frequent respiratory episodes was found in over 80 per cent of the investigated patients with lung cancer. Forty per cent had suffered an almost fatal respiratory sickness in childhood, severe pleurisy, or major chest injuries with pulmonary complications. The most frequent of these illnesses was influenza or pneumonia during the epidemic of 1918-1920 and pneumonia at some other time in the patient's earlier life.

For tentative comparison 86 individuals hospitalized between 1955 and 1957 for various nonmalignant surgical and medical conditions were selected to match the study group as closely as possible in age distribution. They were questioned thoroughly about chronic pulmonary diseases of at least ten years' duration, influenza in 1918-20, and pneumonia at some other time at least ten years prior to their admission. Fully developed bronchitis, which had existed in 65 per cent of the group with lung cancer, was found in 30 per cent of the controls. Similar differences were found also with regard to suspected or proved tuberculosis. Among the patients with pulmonary malignancy the number of those who had influenza in 1918-1920 was twice that among the controls. Multiple episodes of severe pulmonary illness have occurred in 50 per cent of the patients with cancer but in only 19 per cent of the control group.

Current research on the cause of lung cancer concentrates on extrinsic carcinogens in cigarette smoke and air pollution. These studies tend to overshadow others which support anew the older view that tuberculosis and other lung diseases may predispose to pulmonary malignancy. Early cancer in the walls of old bronchiectases, near tuberculous and other scars and in areas of chronic inflammation is being reported frequently. The findings of a multicentric origin of lung cancer and of cancer in situ beside an invasive tumor indicate that generalized pulmonary inflammation can pave the way for bronchogenic carcinoma. These investigations add weight to the concept of a profund cell injury as a cause of the malignant transformation. Severe lung insults of any type merely initiate or further those pathologic changes which produce continuous tissue unrest and disorganized proliferation. The neoplasm may not arise where macroscopically the lung had seemed most damaged. Various factors have been suspected as causes for the present "pandemic of lung cancer." The theory which points toward the pandemic of 1918-1920, may well explain why lung cancer rose sharply following the epidemic and why in recent years a substantial increase is noticeable in the older age group.

In other organs chronic inflammation is widely recognized as potentially malignant. It is, then, conceivable that similar pathologic processes have some part in the genesis of malignant diseased lungs also.

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G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
ATLANTIC CITY	Bayless Pharmacy, 2000 Atlantic Avenue	ATlantic City 4-2600
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	EL 6-0150
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Melcon's Hawthorne Pharm., 207 Diamond Bridge Ave.	HAwthorne 7-1546
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MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-2250
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
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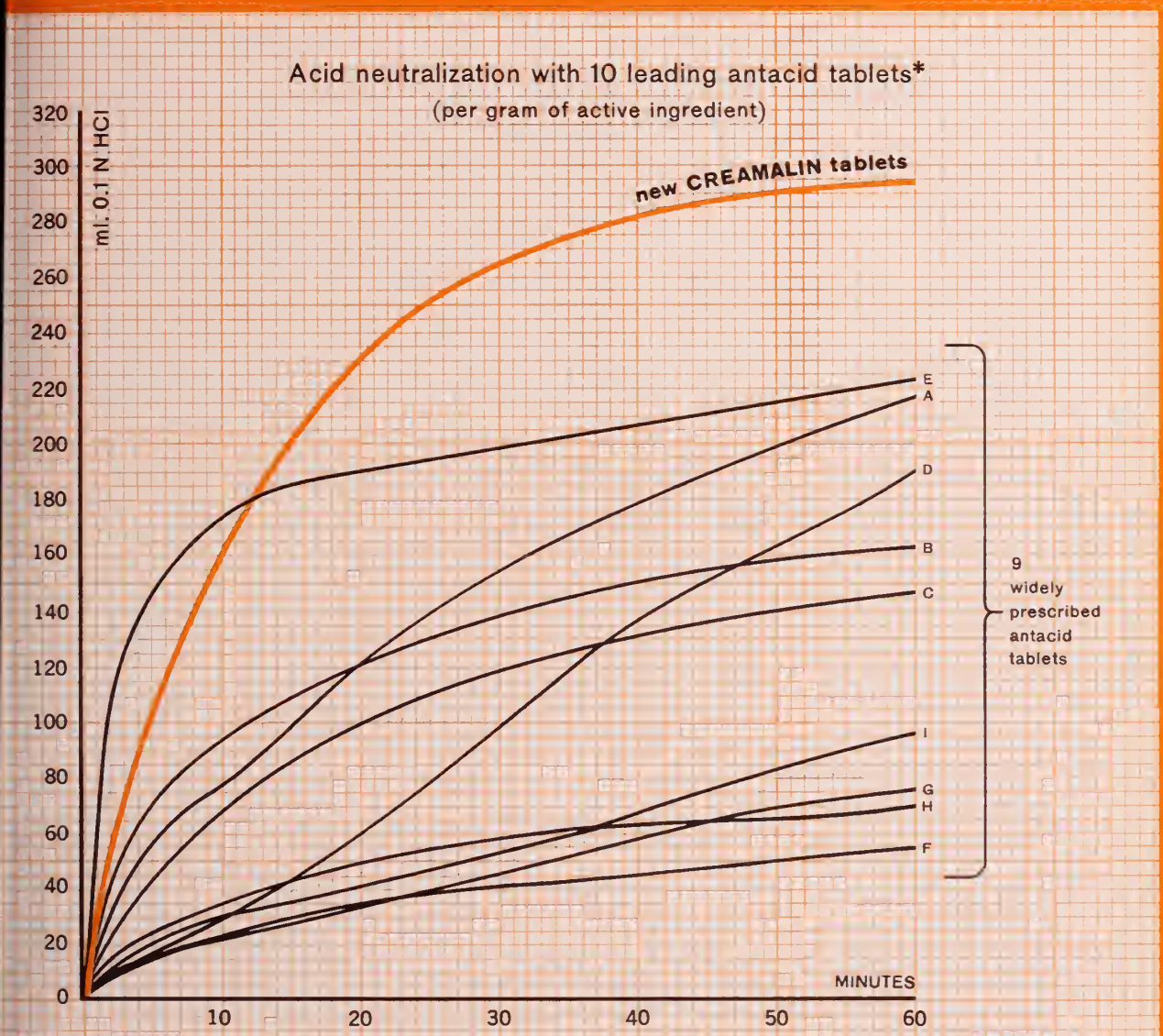
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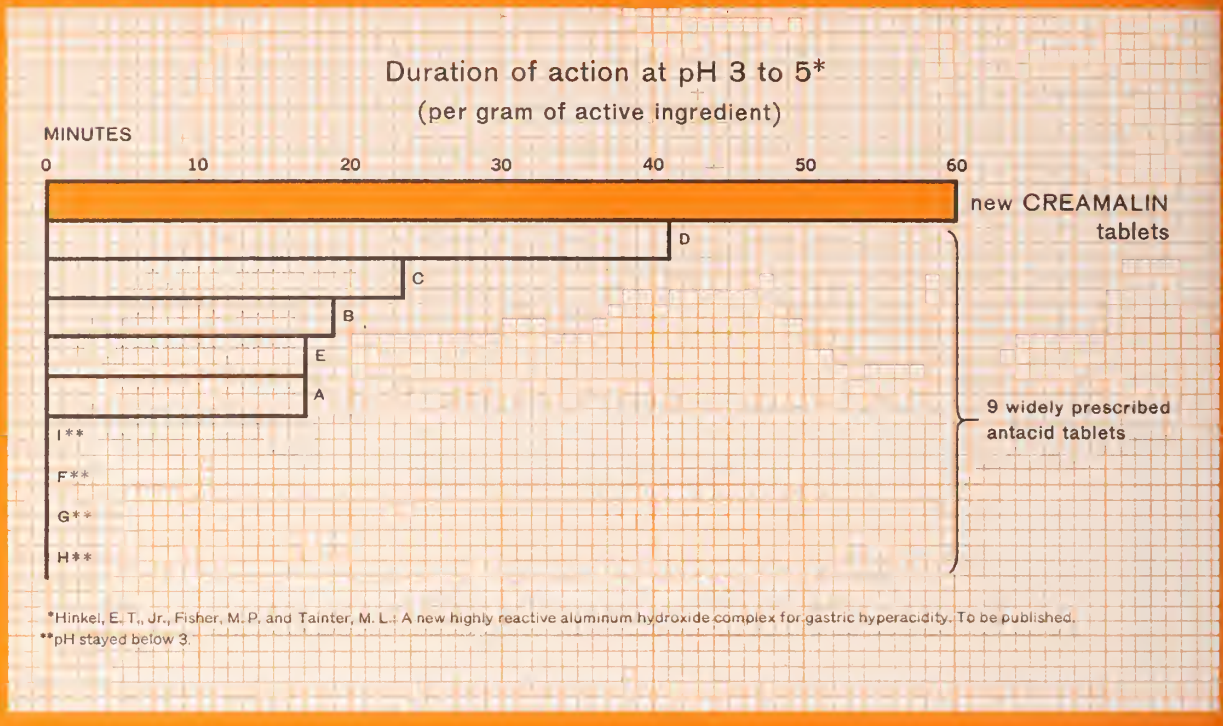


Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain the pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

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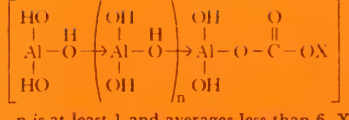
*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.



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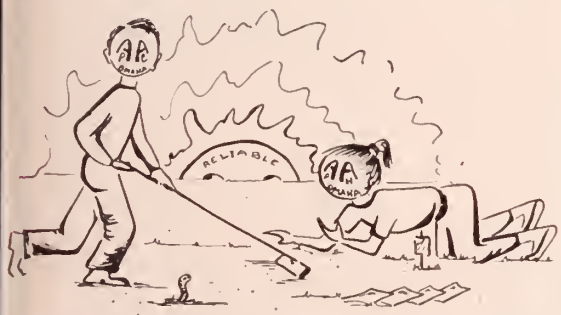
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bibliography: 1. Esch, A. F., Wilson, I. M. and Freis, E. D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959. 2. Ford, R. V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J. **52**:40, (Jan.) 1959. 3. Fuchs, M., Bodi, T., Irie, S. and Moyer, J. H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958. 4. Moyer, J. H., Fuchs, M., Irie, S. and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

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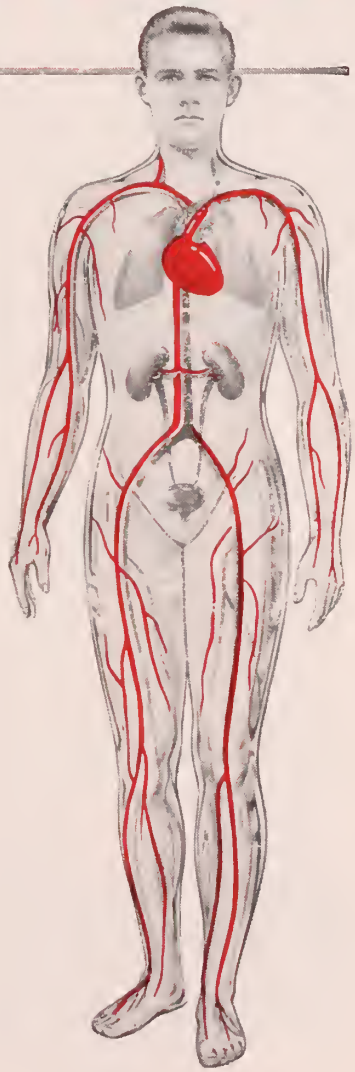
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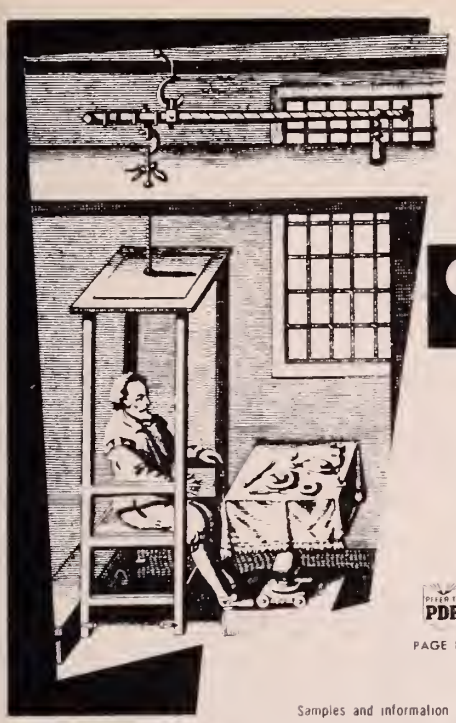
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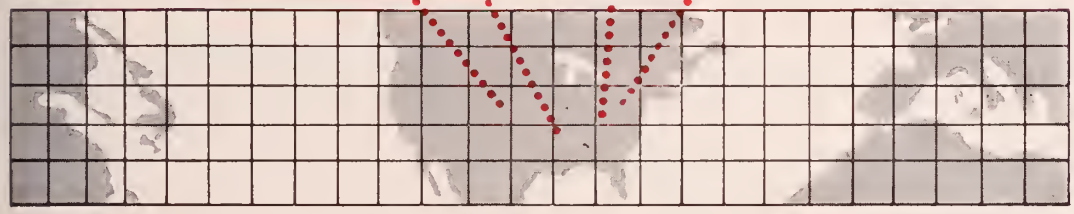
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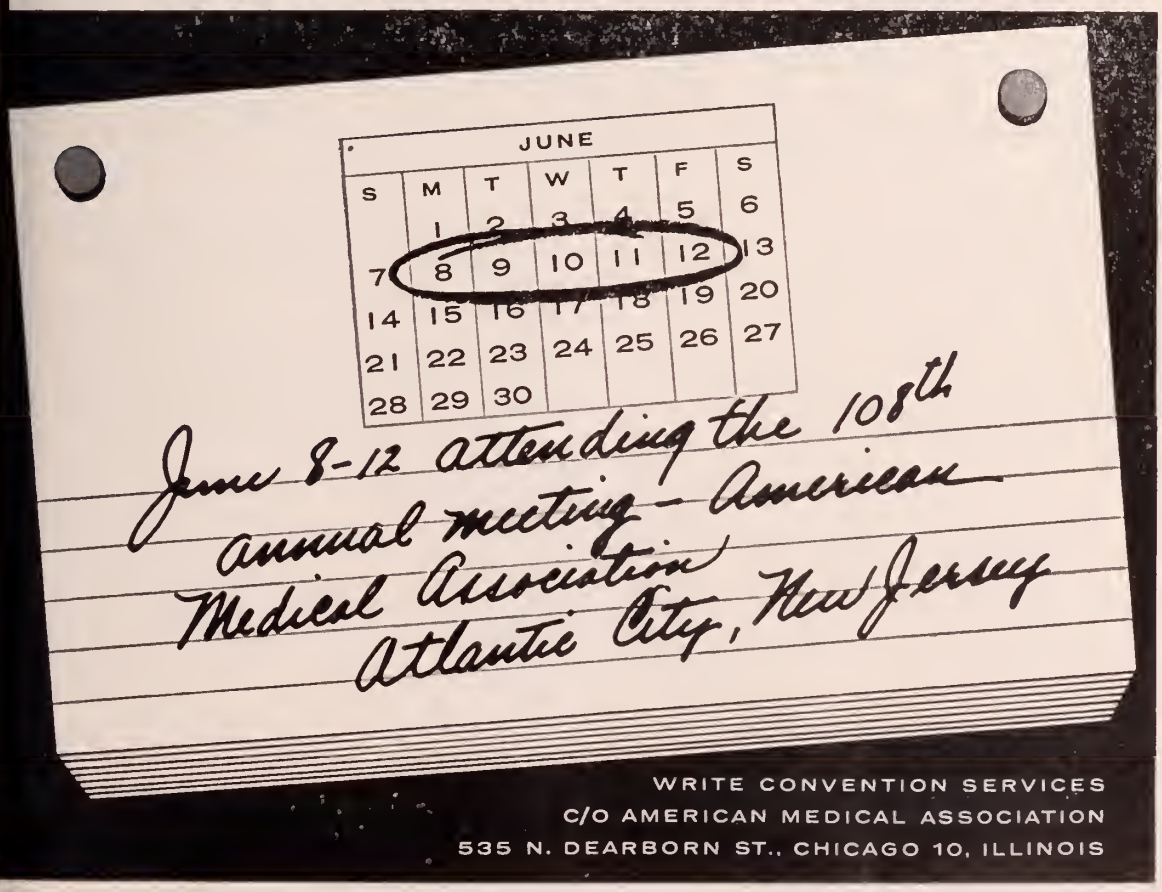
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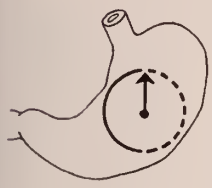
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CONTENTS—Pages 297 to 362

EDITORIALS— Page

Promotion Masquerading as Science 297

Your Blue Shield "Savings Bank" 299

The American Hospital and its Ever-Open Door 299

ORIGINAL ARTICLES—

Diet and Atherosclerosis—Margaret H. Edwards, M.D., *et al.*, Trenton, N. J. 300

Rauwolfia in the Treatment of Hypertension—Burton M. Cohen, M.D., Elizabeth, N.J. 304

Abnormal Uterine Bleeding—Elisabeth B. Ward, M.D., Newark, N. J. 308

X-Ray Stinginess—T. K. Rathmell, M.D., Trenton, N. J. 314

Thyroid for the Thin Patient—Dayton T. Kieswetter, M.D., East Orange, N. J. 316

Microsurgery of Hearing—A. M. Sophocles, M.D., Trenton, N. J. 321

Care of Veterans by Private Practitioner—Samuel H. Sherman, M.D., Newark, N. J. 324

Tinea Capitis—Andrew Kallos, M.D., Kearny, N. J. 327

Therapy of Dermatoses with Perphenazine—S. J. Fanburg, M.D., Newark, N. J. 332

Headache Caused by Masticatory Muscle Contractions—Woodrow S. Monica, D.-M.D., Orange, N. J. 335

ORIGINAL ARTICLES Page

Cancer Program in New Jersey, Part VII. Cancer Rehabilitation 337

A New Agent for Appetite Control—Harold S. Feldman, M.D., Livingston, N. J. 339

Ventricular Standstill—W. Austin Tansey, M.D., Short Hills, N. J. and Richard Wagner, M.D., Summit, N. J. 343

New Gastrointestinal Therapy—Milton E. Landman, M.D., Bloomfield, N. J. 348

SPECIAL ARTICLE—

Your Role in Social Security Disability Determination 350

STATE ACTIVITIES—

N. J. Student Wins Prize 313

C. D. Award to Dr. Karel 313

Radiologic Hazards 353

Annual Report of Burlington County Medical Society 355

ANNOUNCEMENTS 356

COUNTY SOCIETY REPORTS 357

BOOK REVIEWS 359

NTA ABSTRACTS 361

Roster of Officers, Page 3A

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NO MEDICAL EXAMINATION: Insurance will be issued *without medical selection or evidence* of insurability when 30 percent of the eligible members enroll within the enrollment period.

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RENEWAL: The insurance coverage is renewable for the succeeding 5-year periods which begin before your 65th birthday.

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30	60.00	30.60	42	96.00	49.00	54	205.00	104.60
31	63.00	32.10	43	99.00	50.50	55	230.00	117.30
32	65.00	33.20	44	103.00	52.50	56	250.00	127.50
33	67.00	34.20	45	107.00	54.60	57	265.00	135.20
34	70.00	35.70	46	113.00	57.60	58	280.00	142.80
35	73.00	37.20	47	124.00	63.20	59	295.00	150.50
36	77.00	39.30	48	136.00	69.40	60	315.00	160.70
37	80.00	40.80	49	148.00	75.50	61	330.00	168.30
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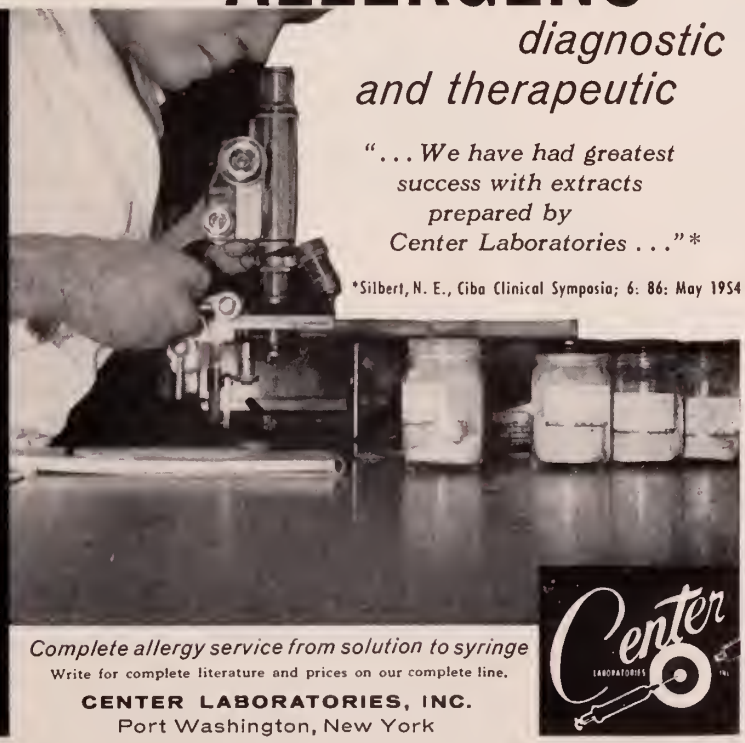
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(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

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150.00	7,500	43.60	50.35	63.8
200.00	10,000	57.70	66.70	84.7
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‡ 600.00	20,000	168.50	195.50	249.5

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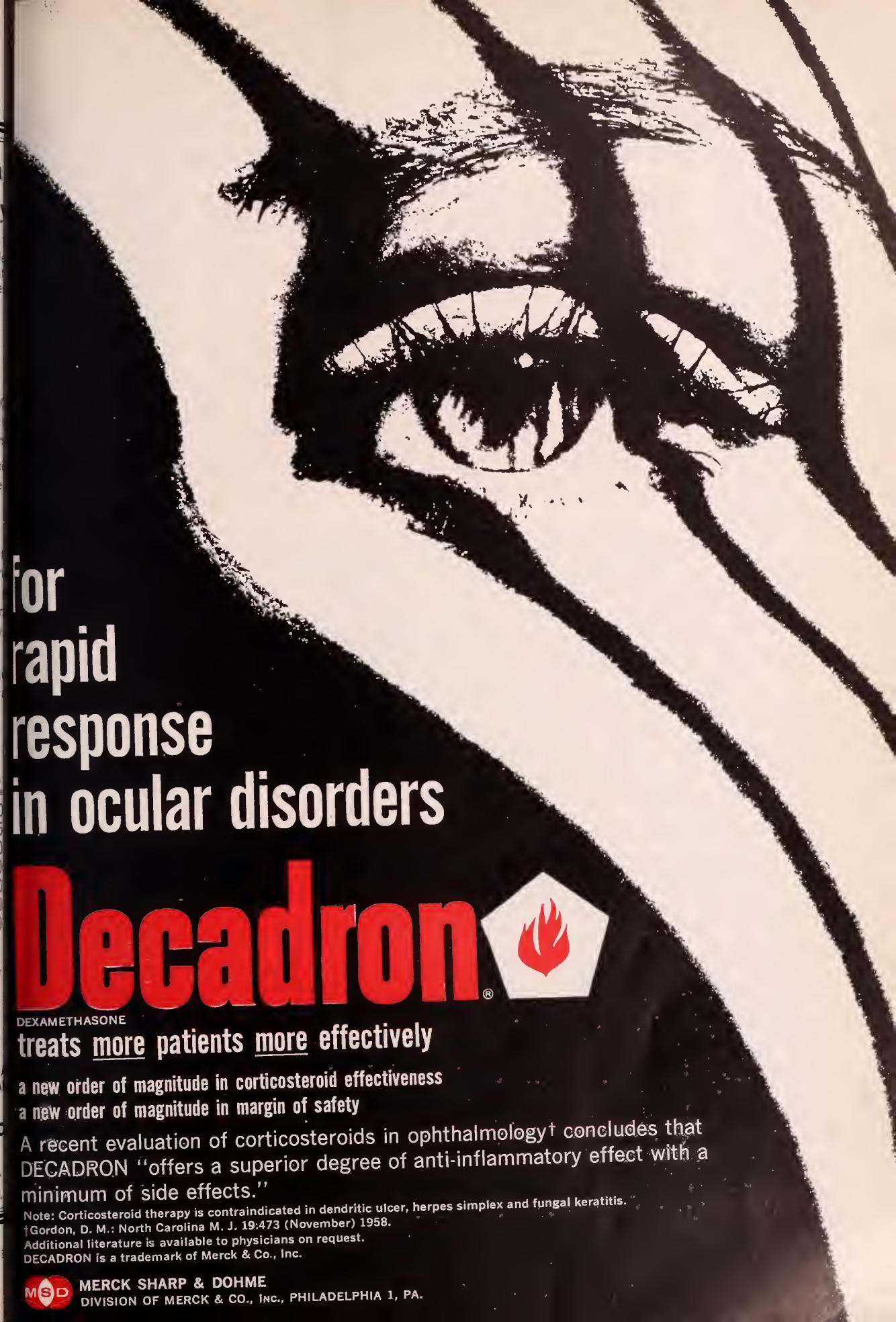
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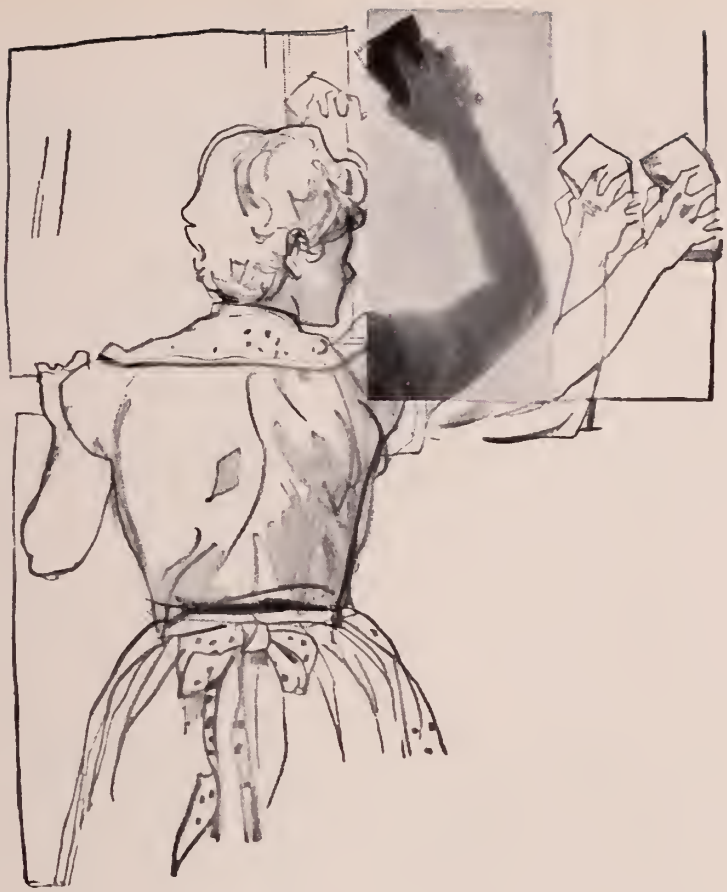


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of nervous, tense patients recovered or improved

For your patients, Miltown promptly checks emotional and muscular tension. Thus, you will make it easier for them to lead a normal family life and to carry on their usual work.

For you, the choice of Miltown as the tranquilizer means the comfortable assurance that it will relieve nervousness and tension without impairing your patient's mental efficiency, motor control, normal behavior or autonomic balance.

meprobamate (Wallace)

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Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

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Through effective relief of anxiety, irritability, insomnia and tension, Miltown aids the patient to "live with his disease," especially during difficult adjustment periods.

Miltown is well tolerated and *"therefore well suited for prolonged treatment in chronic disorders with emotional complications."* (Friedlander, H. S.: Am. J. Cardiol. *1*:395, March 1958.)

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Available in 400 mg. scored and 200 mg. sugar-coated tablets; bottles of 50. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules) and MEPROTABS* (400 mg. *unidentifiable*, coated meprobamate tablets).

When mental depression complicates chronic disease: DEPROL* (1 mg. benactyzine HCl plus 400 mg. meprobamate). *TRADE-MARK

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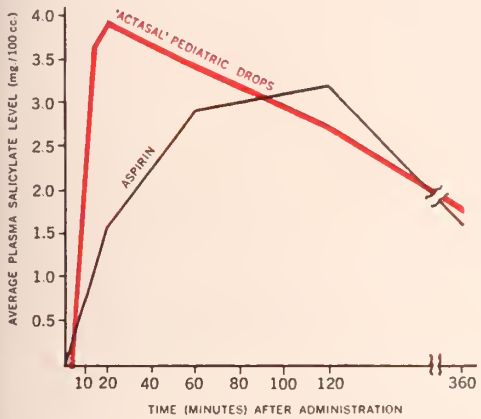
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ASSURES PEAK SALICYLATE LEVELS 5 TIMES FASTER THAN ASPIRIN[1,2,3]—WITH PROVEN BETTER GASTRIC TOLERANCE.



Comparative Plasma Salicylate Levels After Oral Administration of Doses of 'Actasal' Pediatric and Aspirin, Providing Equal Amounts of Salicylate.

Clinically proved – In thousands of cases by more than 180 investigators[4]

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A new and unique salicylate molecule in palatable solution.

DOSAGE: Each dropperful (0.6 ml.) contains 105 mg. Choline Salicylate, equivalent to approximately 1¼ grains aspirin.

Children 6-12 years: 2 to 4 dropperfuls every 3 to 4 hours, or as required. Children 3-6 years: 1 to 2 dropperfuls every 3 to 4 hours, or as required. Children under 3 years: 1 dropperful every 3 to 4 hours, or as required.

SUPPLY: 60 cc. bottle packaged with cellophane-wrapped calibrated dropper.

CITED REFERENCES: 1. Smith, P. K.: Personal Communication. 2. Wolf, J., Aboody, R.: Federation Proc. 18:605, 1959. 3. Broh-Kahn, R. H.: Federation Proc. 18:17, 1959. 4. Complete data available on request to the Medical Director.

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CONTAINS CERAPON-C* 12.0% IN PROPYLENE GLYCOL WITH PARABENS 0.1% AND TYROTHRICIN 0.1%. PURDUE FREDERICK *BRAND OF TRIETHANOLAMINE POLYPEPTIDE COCOATE-CONDENSATE

Specifically prepared for safe, effective removal and prevention of cradle cap, by combining unique proteo-lipid sebulytic effect with anti-infective action.





Bialkin, G.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959.

CASE HISTORY: J. D., a 5 month old white male developed a dry seborrhea capitis at approximately 6 weeks after birth which covered the whole scalp. By the time of examination, the child had been treated with various detergent ointment and lotion preparations without apparent effect. 'Soropon' Pediatric Solution was applied as a shampoo, directly to the scalp to remove the encrustations. A lanolin ointment was applied to scalp because of inherent dryness. A series of 5 treatments was required for complete removal and after this treatment period the seborrheic eczema had virtually disappeared. The patient has been symptom free since then.

Bialkin, G.: A New Anti-Seborrheic Agent in Pediatric Practice. Arch. of Ped. (to be published).

SUPPLY: 'Soropon' Pediatric Solution is available in bottles of 4 oz.

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Effective relief in rheumatic disorders

Sterazolidin® capsules

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Geigy

with less risk of disturbing hormonal balance



In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

Repeatedly it has been shown that the addition of low dosage of Butazolidin sharply reduces hormone requirement.[1-4] Sterazolidin is a combination of prednisone (1.25 mg.) and Butazolidin (50 mg.) which provides, in the majority of cases, consistent relief at a stable uniform maintenance dosage significantly below the level at which serious hormonal imbalance is likely to occur.

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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

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Also available as a pleasant-tasting cherry-flavored elixir (5 mcg. per 5-cc. teaspoonful) and as REDISOL injectable, cyanocobalamin injection USP (30 and 100 mcg. per cc., 10-cc. vials and 1000 mcg. per cc. in 1, 5 and 10-cc. vials).

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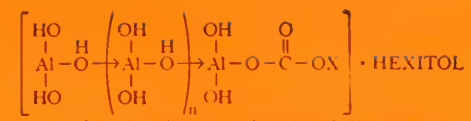
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1. *Neutralizes acid faster (quicker relief)*
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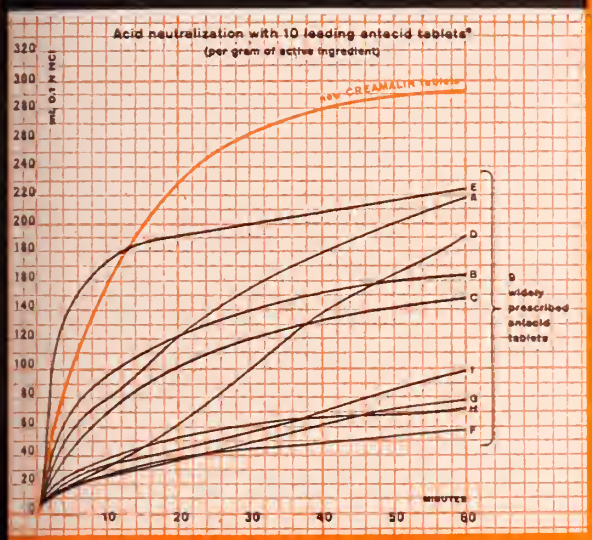
a new high in effectiveness and palatability



n is at least 1 and averages less than 6. X is a cation.

CREAMALIN neutralizes *more* acid *faster*

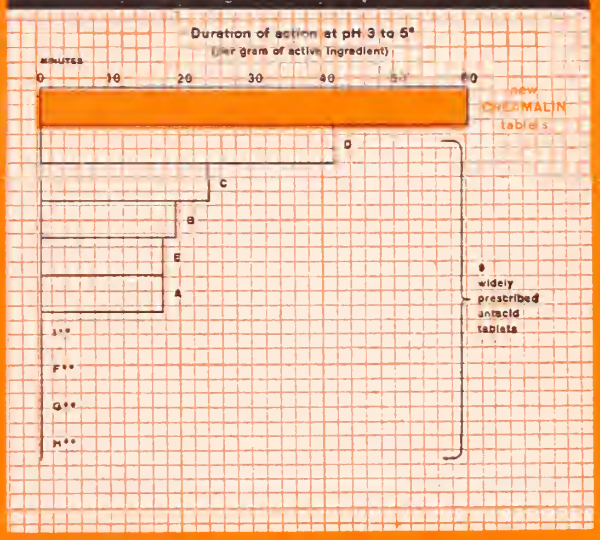
Quicker Relief • Greater Relief



Tablets were powdered and suspended in distilled water in a constant temperature container (37° C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour

CREAMALIN neutralizes *more* acid *longer*

More Lasting Relief



*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.





No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

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Dealing with General Electric is like owning your own complete warehouse of x-ray supplies. You get fast action on every order from any of 68 strategically located factory-operated offices.

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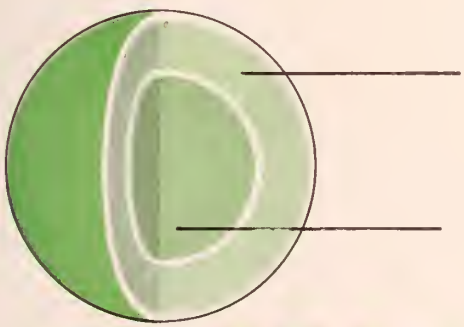
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the complaint: "nervous indigestion"

the diagnosis: any one of several nonspecific gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy. **the prescription:** a new formulation, incorporating in a single tablet the actions of Donnatal and Entozyme. **the dosage:** two tablets three times a day, or as indicated.



the formula: *in the gastric-soluble outer layer:*

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (⅛ gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

in the enteric-coated core:

Pancreatin, N.F.	300 mg.
Bile salts	150 mg.

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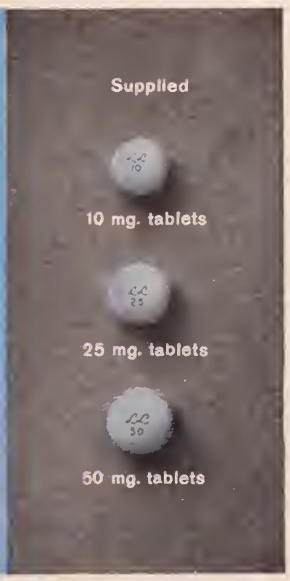
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Positive, rapid calming effect in mild and moderate cases. Striking freedom from organic toxicity, intolerance, or sen- ity reaction—particularly at low dosage. Greater freedom n induced depression or drug habituation. May be use- as with other tranquilizers, to potentiate action of analgesics, ntives, narcotics. Facilitates management of surgical, tetric, and other hospitalized patients. Indicated when e than a mild sedative effect is desired...and less than psy- sis is involved. Dosage range: *In mild to moderate cases:* n 30 to 100 mg. daily. *In moderate to severe cases:* from 75 to mg. daily.

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Lederle



new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions

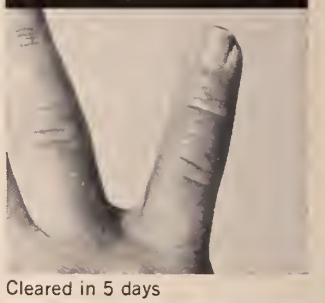
Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

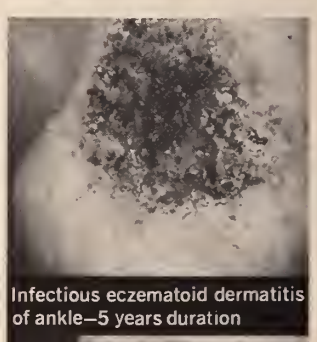
antipruritic/anti-inflammatory/antibacterial/antifungal



Dermatitis repens [with staph and monilia] 7 weeks duration



Cleared in 5 days



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] — neomycin and gramicidin for powerful antibacterial action[7] — and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.; Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available — Kenalog-S Lotion — 7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1% — 5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1% — 15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1% — 5 Gm. and 15 Gm. tubes.

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in the depressed, unhappy patient

PROMPTLY IMPROVES MOOD

without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.

EFFICACY AND SAFETY CONFIRMED IN OVER 3,000 DOCUMENTED CASE HISTORIES.[1, 2, 3]



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each light-pink, scored tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

References:

1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

for depression

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Dimetane works in all symptoms of allergic rhinitis; and in urticaria, atopic and contact dermatitis. The summary conclusion of extensive clinical studies to date: Dimetane provides unexcelled antihistaminic potency with minimal side effects.
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(parabromdylamine maleate)



in surgical and obstetrical procedures
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OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



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the means *(second to none)*

to end nausea and vomiting

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perphenazine

INJECTION • SUPPOSITORIES • REPETABS • TABLETS

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- *frees* patients from daytime drowsiness
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5 mg. ampul of 1 cc.

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8 mg.—4 mg. in outer layer for *prompt effect*, 4 mg. in inner core for *prolonged action*

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(1) Ernst, E. M., and Snyder, A. M.: Pennsylvania M. J. *61*:355, 1958.

(2) Preisig, R., and Landman, M. E.: Am. Pract. & Digest Treat. *9*:740, 1958.

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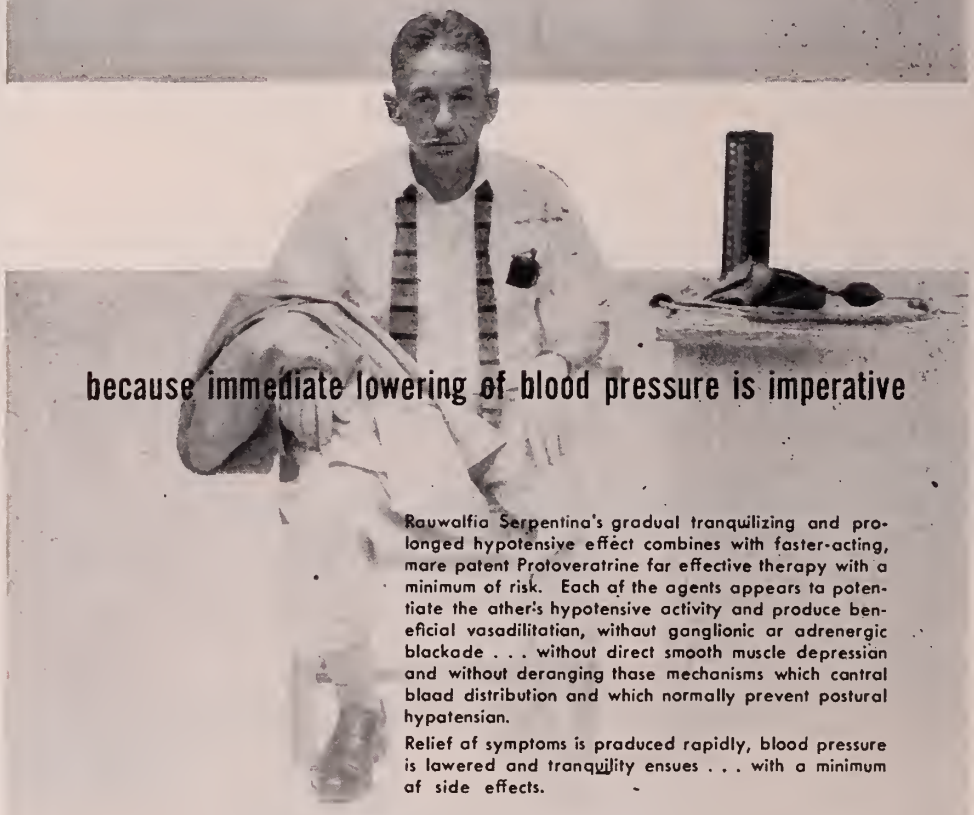
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prescribed: **Rauprote***

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Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

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Sulfamethoxypyridazine Lederle

provides therapeutic sulfa levels for 24 hours... Highly soluble... rapidly absorbed... produces fast, sustained plasma-tissue concentrations. Simple, easy-to-remember, single 0.5 Gm. daily dose. No crystalluria. [1]

with low incidence of sensitivity reactions... Extremely low in toxic potential. [2,3] No cutaneous or other objective reactions seen in a wide scale study of clinical toxicity. [2] Even minor subjective reactions are not expected to occur [2] or are reported absent [3] when recommended schedule is used.

TABLETS, 0.5 Gm., bottles of 24 and 100. New ACETYL PEDIATRIC SUSPENSION, cherry flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.), bottles of 4 and 16 fl. oz.

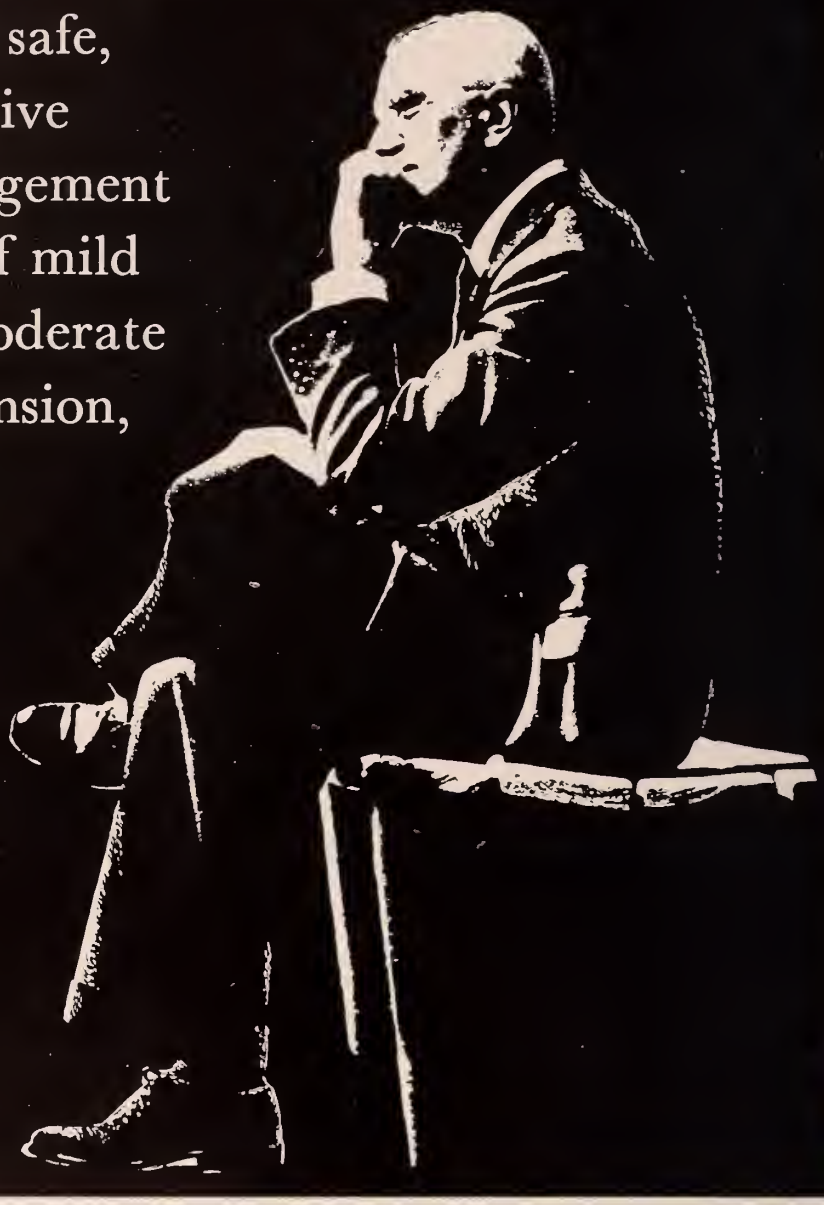
1. Editorial: New England J. Med. 258:48, 1958.
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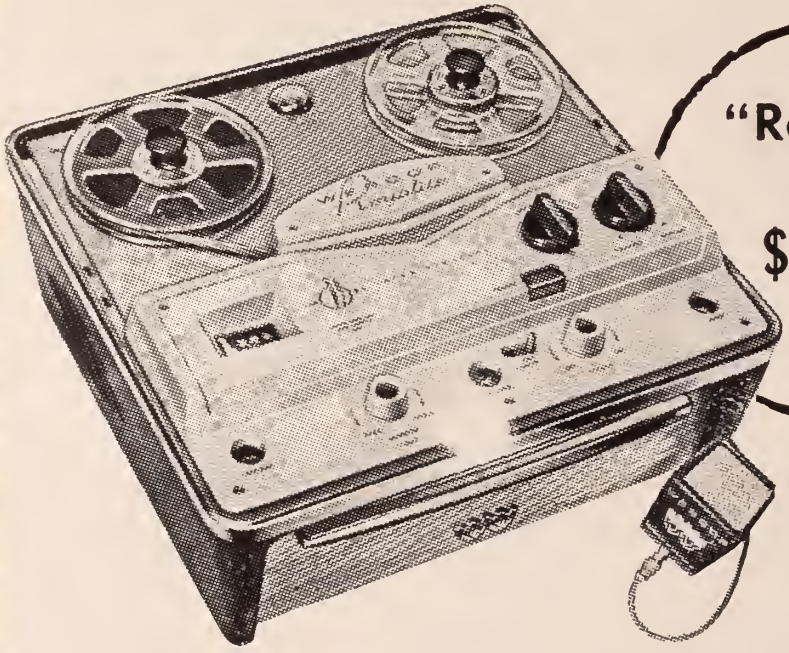
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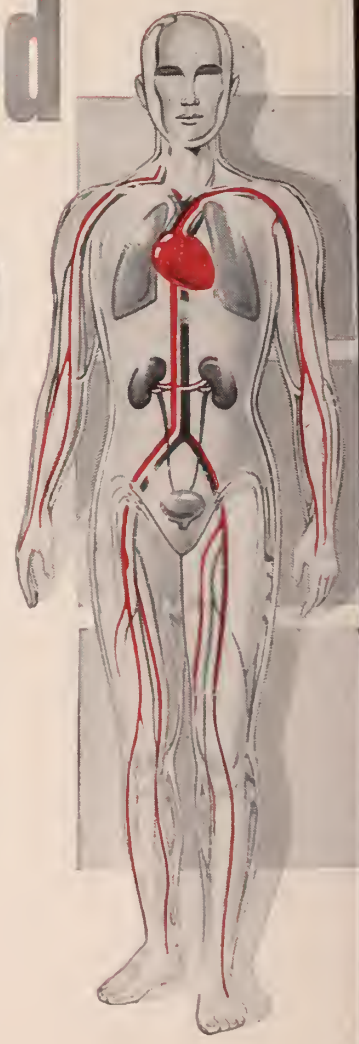
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Editorials • • •

Promotion Masquerading as Science

Every knowledgeable physician must tip his hat to the pharmaceutical industry for its dedicated, often selfless, research in pharmacology. In spite of this accolade, however, we must raise our eyebrows at another aspect of drug promotion. We refer to the planting of a bit of advertising under the guise of a scientific article. The sequence of events runs something like this.

Nonesuch Laboratories, manufacturers of ethical drugs, have developed Oomph®, a new week-end capsule which combines aphrodisiac power with anti-hangover properties. They find a doctor in a not too distant city who is willing to do the "research." The company furnishes the practitioner with a thousand, or maybe ten thousand, capsules of Oomph®. The doctor gives the capsule to a variety of patients, and, under the guidance of an official from Nonesuch Laboratories, he appraises the results. Much improved: 88 per cent. Definitely improved: 9 per cent. Unchanged: 2 per cent. Worse: 1 per cent. The doctor then drafts a paper replete with tables like this:

Diagnosis	Much Imp.	Def. Imp.	Un-Changed	Apparently Worse	Total
Logus on bogus	9	2	1	0	12
Puck, non supp.	30	2	0	0	32
Crud, subacute	25	3	1	0	29
Housemaid's knee	24	2	0	1	27
	88	9	2	1	100

The draft is sent to the Public Relations Division of Nonesuch Laboratories. There an expert "edits" (*i.e.* rewrites) the paper. The author is dazed into believing that all the expert did was change a few commas or unsplit a few infinitives. In his heart he knows that the expert threw away the draft and wrote his own. The paper is then sent to a medical journal, preferably one put out by an organization to which the haunted author pays dues. When galleys are returned, the author swiftly relays them to the Nonesuch Laboratories. The edi-

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tor can tell because of the slick professional tone of the proof-reading, replete with trade jargon like "stet" and "l.f. caps." Two weeks after the paper is accepted, the journal gets a letter signed by the Director of Research at Nonesuch Laboratories, stating that the Laboratory would like to buy 150,000 reprints—or if the journal is going to be slow in releasing the opus, they would like to buy that many preprints(advance of publication). The happy author looks for a niche in medicine's Hall of Fame—somewhere between William Osler and William Mayo. For two years thereafter, every mailing sent out by Nonesuch Laboratories is stuffed with reprints of this arbeit, or with abstracts from it. "Highly effective in treatment of subacute crud—" or "No untoward effects in 32 cases of nonsuppurative cold." Nonesuch also pay for advertisements in which our doctor's findings are mounted.

The companies usually want the author to use the tradename repeatedly. If they issue a brand of sodium chloride tradenamed Nauseasal®, they want the editor to keep printing Nauseasal® instead of sodium chloride (Nonesuch). The more sophisticated companies, however, have a more subtle gimmick. Their drug is mono-duo-tetra-ethyl-lead-muskine, tradenamed Panaceine®. They let the author keep referring to it as mono-duo-tetra-ethyl-lead-muskine and apparently abandon the tradename. But any reader who wants to duplicate the author's result (97 per cent improved), has to go to the local pharmacist to find out how in blazes they can get mono-duo-tetra-ethyl-lead-muskine; and it turns out that it is Panaceine®. In this case the manufacturer can wear an aura of great sanctimony since he does not mention the tradename in the promotional manuscripts.

On behalf of the promoters, it must be admitted that some important medical discoveries have been developed this way. In favor of company-inspired private-practitioner research, it has been argued that in the experimental stage, it is only fair to supply free supplies of the drug. Also, it is pointed out that the average practitioner is unfamiliar with proof-readers' marks and with statistical technics. Therefore why can't the company furnish experts in both?

To which there are several answers. No one objects to the companies conducting research in their own laboratories. Such activities do not sail under false colors. Company-sponsored research has brought the American public some of its most wonderful pharmaceutical boons. However, when a presumably independent private practitioner releases his results, the picture changes. If it is released under his name, the casual reader assumes that it is an independent study. If, in truth, it was supported by the company, this should be made clear. Often it isn't. Sometimes the doctor is compensated for his time—but doesn't advertise that fact. In effect, he becomes a captive of the company which furnishes him with free medication, free consultation, free stenographic assistance and so on. It takes courage for a practitioner to accept all these gifts, and then say: "Gentlemen, my study shows that Panaceine® is completely ineffective." Indeed, it almost sounds like cheating to do that.

So it is easy to rationalize a good result. The patient is pleased with all this attention, with the frequent re-examinations, with being a participant in a noble experiment. Oh yes, he says, I do feel better. (Tally one in the *improved* column, please). Untoward results? Well, mild itching, easily controlled. Some headache—probably psychic. No untoward results worth mentioning except as mild or readily neutralized trivia.

So the doctor, unwittingly, lends his name to a private promotion. He gets a brief moment of glamor—his name in a journal, and possibly a fine dinner or a day's outing at company expense—and sees himself as the Jonas Salk of '59. But, on the morning after he may (or may not) realize that this work will really not stand rigid scientific scrutiny and that he has lent his name to the promotion of a privately vended proprietary.

We are all in favor of pharmaceutical advertising. But we hope it will be clearly labeled as such. It is a disservice to the profession to publish a puff for a new product under the guise of a scientific article.

Your Blue Shield "Savings Bank"

Dr. R. B. Carson, in an address before the 1958 National Blue Shield Professional Relations Conference, compared Blue Shield to a savings bank, in which the patient places regular deposits against the day when he needs money to pay for medical care. "From the doctor's viewpoint," Dr. Carson pointed out, "this savings bank became an extension of our own front offices because it was maintained by our own board of trustees. We do our own collecting and disbursing without deduction of a profit and without interference from any third party telling us how, when, or to whom the disbursement should be made. We doctors had control of these banks."

But if we doctors are to benefit from Blue Shield, we must take an active, responsible interest in our Plans. And if we want our patients to continue making their deposits in the Blue Shield Bank, then we must demonstrate, day after day, that both Blue Shield and its sponsoring physicians are first serving the welfare of our patients.

The role of the doctor, says Dr. Carson, "must be that he once again become an integral, interested, cooperating part of the idea and ideals of the Plan."

The American Hospital and its Ever-Open Door

People enjoy television but they don't enjoy sickness. From this flows the fact that people resent paying hospital bills, while they think that they're getting their money's worth out of the visit of a TV repair man. And, of course, hospital bills are high today, and when you add the extra charges the tariff may seem out of this world to the average patient. Hospitals usually defend their apparently high bills by showing that actually they are losing money. Such an argument may be logically sound but it is not psychologically sound. People are really not interested in the vagaries of hospital bookkeeping. Perhaps the hospital should take the offensive and point out what it means to the community—rather than become defensive. Or they might tell the public something like this.

"There is a door that always opens in our community. When the windows of homes and stores are dark and the whole city seems to be sleeping, a light can be seen behind a door marked 'Emergency Entrance' in the hospital. This is one of the most important buildings in the community. Even our smallest hospital can offer more roads to recovery than were available in the great medical centers a few decades ago. And the big medical centers today are developing the 'routine' services of tomorrow.

"For every forward step that has reduced the need for hospitalization today, there are other advances bringing to the hospital new groups of patients with new hopes of recovery.

"The hospital stands ready 24 hours a day, 7 days a week, around the year to meet the most unpredictable needs. It must be prepared for individual emergency and community disaster. Let us accolade the institution that never closes its doors!"

Perhaps this might make some people grateful that they have a hospital in the community. This might make it clear that by paying hotel prices, they are getting service in a very superior kind of hotel. Of course, the words are corny, and the approach is frankly sentimental. But let it be remembered that, sentimental or not, it's true what they say here about hospitals—true, all true.

MARGARET H. EDWARDS, M.D.
ANNE E. CALDWELL, PH.D.
MARGARET ZEALAND, M.S.*

Trenton

Diet and Atherosclerosis

Is the present interest in plant fats and unsaturated oils scientifically rooted? Will an alteration in fat intake ratios reduce the chances of atherosclerosis? Or do the commercial low-fat or unsaturated-fat products represent a racket rather than a scientific control technic? The authors from our State Health Department don't have all the answers, but—

A CHOLESTEROL haze on the medical horizon has obscured our vision concerning heart disease and atherosclerosis. As through a glass darkly, we catch glimmerings of unsaturated fatty acids, low-density lipoproteins, and unfamiliar vegetable oils. Visions of exotically-fed chickens, rabbits and rats dance through our heads while we see various population groups standing or falling according to the proportion of blubber, butter, rice, olives or peanuts which they ingest. The detail man's foot is in the door with numerous products demonstrated to lower serum cholesterol. Popular magazines have taught the public they are digging their graves with their own oil-dripping teeth.

Surely, the most attractive form of therapy or prophylaxis for any disease, both to doctor and patient, is the use of an oral agent which will busily go to work and do the job. No therapeutic regimen based solely on readjustment or regulation of man's basic behavior will ever compete with his wish to be kept healthy by means of pills. Dietary regulation, therefore, will never be popular, especially when it involves the replacement of that which is appetizing by that which is not.

The busy physician is in a quandary. Is he withholding benefit from his patients by failing to check their serum cholesterols, give them cholesterol-lowering agents, or place them on low-fat diets, while he waits for enlightenment? How long should he maintain a conservative attitude? Is weight-reduction *per se* as important as changes in the fat content of the diet? And at what ages are dietary regulations most likely to be effective in preventing atherosclerosis?

Out of the welter of published information, much of it conflicting, irrelevant, or unsubstantiated, regarding the relation between diet, atherosclerosis and heart disease, there are some facts which emerge and which can illuminate, if not solve, the problem of cardiovascular disease prevention and control. Numerous attempts [1] to sort, compile and correlate these pertinent data have recently appeared. This paper is essentially an analysis of these summaries and other recently available material.

*Dr. Edwards is Public Health Physician, Division of Chronic Illness Control, New Jersey State Department of Health. Dr. Caldwell is the Chairman of the New Jersey State Nutrition Council and Mrs. Zealand is Coordinator of the Nutrition Program, New Jersey State Department of Health.

THE PROBLEM

ATHEROSCLEROSIS, and in particular coronary heart disease, and the morbidity and mortality due to these, are serious problems in North America today. There has been no alarming increase in their incidence,[2] but in our population there is a higher incidence of these entities than in most other countries.

The gradual aging of our population by longevity has increased the incidence of arteriosclerosis and its attendant cardiovascular, renal and cerebral complications. *Arteriosclerosis* broadly covers all arterial changes leading to loss of elasticity, thickening and hardening of the arteries. *Atherosclerosis* refers to changes primarily involving the media and associated with the formation of *atheromata*. *Senile arteriosclerosis* is characterized by medial fibrosis, and *Mönckeberg's sclerosis* by medial thickening. As age advances and arteriosclerosis develops, the incidence of thrombosis in association with arteriosclerotic heart disease increases. While there is no known relationship between *arteriosclerosis* and diet, predisposition both to thrombosis and *atherosclerosis* can be associated with elevations of blood lipids, so that the two problems, impairment of arterial patency and thrombus-formation must be analyzed together.

ETIOLOGY

MANY factors have a distinct relationship to the incidence of human atherosclerosis and coronary heart disease. These are:

(a) Heredity [3] (race and genetic background)
(b) Age [4]
(c) Sex [5]
(d) Anatomy of blood vessel walls [6]
(e) Diabetes [7]
(f) Arterial blood pressure [8]
(g) Physical activity [9]
(h) Stress [10]
(i) Diet [11]
(j) Obesity [12]
(k) Lipid content of the blood [13]
(l) Clotting mechanisms [14]

Emphasis on, and the relationships among, the last four of these factors began to be studied in 1856 when Virchow observed the lipid content of human atheromatous tissue. In 1913 the first arterial lesions were produced in rabbits by cholesterol feeding. Since then, dietary fat moieties have been subjected to increasing and rapidly intensified scrutiny in a search for a solution to the problem of arterial disease. The high fat content and the preponderance of animal fat in the average American diet have been blamed, perhaps wrongly, for an increased incidence of coronary atherosclerosis. Similarities between the lipid content of atheromatous tissues [15] and the blood lipid pattern of individuals with coronary heart disease [16] have been used as proof of cause and effect. Finally, the regression of experimental atherosclerosis under dietary manipulations and supplements has spurred similar clinical trials, and enthusiastic reporting of small series of cases.

FAT METABOLISM

FATS ingested in our food are mixtures of true fat, glycerol esters, saturated and unsaturated fatty acids. The essential fatty acids are arachidonic, linolenic and linoleic, the latter the least saturated, *i.e.*, having the most double-bonds. Other food fats include plant and animal sterols, such as sitosterol, present in the unsaponifiable portion of corn oil, for example; and cholesterol, present in meat, cheese and eggs; and tocopherol. The body can synthesize fats from carbohydrate and protein in the presence of certain vitamins. Synthesis of the essential unsaturated fatty acids, however, such as linoleic and arachidonic, is strictly limited, and deficiency symptoms appear when they are inadequately supplied.[17] A true deficiency is rare however; the average American diet contains from 25 per cent to 40 per cent fat. Survival is possible[18] on fat levels as low as 5 per cent.

Ingestion of fat results in a rise in serum phospholipids, triglycerides, lipase and cholesterol. These changes can also be induced by increasing the caloric value of a diet in its protein and carbohydrate fractions.[19] The ingestion of *highly saturated* fats *elevates*, and of *unsaturated* fats *lowers* the serum cholesterol and phospholipids; but the serum triglycerides are unaltered.

Movement of the serum lipid fractions into the blood vessel wall and the formation there of atheromatous plaques, is not understood. Cholesterol and phospholipid can be synthesized in the blood vessel wall itself.[20] Tagged fat moieties are incorporated into vascular atheromata.[21] Experimental arterial lesions can recede under appropriate conditions.[22] Excretion of cholesterol can be increased at the same time serum cholesterol levels are lowered by dietary manipulations.[23] Hence, the aim of much medical research has been to link dietary factors specifically with the development of atherosclerosis (and attendant thrombosis); then to elucidate means whereby this may be detected, prevented, or reversed.

LIPIDS

Reduction in serum cholesterol can be brought about by dietary alterations consisting of (1) reduction in total intake of calories, (2) reduction in fat (or protein) content of the diet, and (3) reduction of the proportion of animal fat in the diet, with substitution of certain vegetable oils. Most investigation has centered about this third factor, in the hope that a direct connection between animal fat and atherosclerosis might be found, thus explaining its greater frequency in countries where butter and meat are eaten more liberally. It is hoped too, that a factor in plant oils might be revealed which would lower serum cholesterol and prevent or reverse atherosclerosis. To date there is no conclusive proof for either theory sufficient to warrant widescale drastic dietary revisions; but evidence is accumulating bit by bit which foreshadows such an event.

Severe restriction or elimination of dietary fat will result in lowered serum cholesterol, regardless of the type of fat which has been ingested. It has, therefore, been difficult to construct experiments in which single fats or various of their constituents can be evaluated. However, there is no doubt that the degree of unsaturation of fats used, strongly correlates with serum cholesterol levels, provided the total proportion of fat is unaltered. Of various oils studied, safflower is the least saturated, corn and cottonseed oil next, whereas chicken fat, lard, beef fat and butter are highly saturated. Careful studies of the effects of these fats on blood lipid concentrations reveal uniform depression with corn oil and other unsaturated vegetable oils, and constant elevation with animal fats.[24] The degree of hydrogenation adversely affects the lipid-lowering activity of corn oil, whereas removal of the non-saponifiable fraction (containing the sterols and vitamins) does not. It is still not known which constituent in vegetable oils brings about blood lipid depression, but relationship both to the degree of unsaturation and the absence of short-chain fatty acids is strongly suggested. The cholesterol lowering effect of sitosterol, a constituent of some plant oils (cottonseed, linseed) is less marked.[25]

LIPID LOWERING AGENTS

Lipotrophic agents are those which have been shown, in animal experiments, to prevent abnormal deposition of fat in the liver. Among these are choline and its oxidation product, betaine, the B-vitamins including inositol, and methionine (an amino-acid). The effect of these agents on human atherosclerosis, once thought important, has not been substantiated.[26] The cholesterol-lowering value of corn oil, unsaturated fatty acids and other plant sterols, however, has been exploited by commercial laboratories and by plant oil industries. Examples of these follow:[27]

Unsaturated fatty acids

Lenic (Crookes-Barnes): linoleic acid, oleic acid, tetra-, penta-, and hexa-enoic acids

Linodoxine (Pfizer): linoleic acid, pyridoxine and mixed tocopherols

Lufa (U. S. Vitamin Corp.): linoleic acid, pyridoxine, choline, methionine, inositol, liver and vitamins

Unsaturated oils

Arcofac (Armour): safflower oil and pyridoxine

Atheroxin (Gray): refined corn oil and pyridoxine

E F A (Columbus): Soybean oil, soybean, lecithin and pyridoxine

Emdee (Pitman-Moore): corn oil, vitamins A and D

Saff (Abbott): safflower oil and water emulsion

In addition, more than twenty preparations

are available consisting of various combinations of lipotrophic agents, primarily choline, inositol, and methionine, with and without other vitamins. Sustained, long-term studies on any of these preparations have not made their way into the literature, but it is questioned whether they provide a solution to so broad a problem, anymore than does the cholesterol depression which may be produced by administration of thyroid-substances or estrogens. Lecithin,[28] and nicotinic acid[29] (niacin) in large doses have been reported to have beneficial effects on hypercholesterolemia, but to no greater degree than that provided by the use of vegetable oils, nor are there long-term reports on their effectiveness in preventing arterial changes. Finally, the lipid clearing action of heparin[30] has not been demonstrated to prevent or ameliorate atherosclerosis.

LIPID MEASUREMENTS

THE use of serum cholesterol determinations to evaluate the effectiveness of atherogenic agents, as well as index of the presence of atherosclerosis, is open to some question as long as the relationship between the blood lipids and atherosclerosis remains unclear. Neither the cholesterol determination nor the "atherogenic index" (derived from the relationship of lipo-protein densities) can be relied upon as predicting a probably serious coronary arterial lesion.

In clinical practice, however, *serial* determinations of serum cholesterol values are useful as indicating, when elevated persistently, a trend toward atherosclerosis and are as valid as the more costly and difficult lipo-protein determinations.[31] Physicians who secure blood cholesterol measurements on their patients must remember that many factors, including stress and exercise, as well as food intake, alter cholesterol levels, and a careful evaluation of these is mandatory to their proper interpretation.[32]

SUMMARY AND CONCLUSIONS

1. Evidence is accumulating which indicates a close relationship between high dietary fat intake and the development of human atherosclerosis. Reflections of each of these factors are found in elevated serial blood lipid determinations, although no direct relationship can be more than inferred. There is reason to suspect animal fats of a more atherogenic role than fats of plant origin, and serum lipid reductions may be obtained both by reducing or altering the fat ratios in the diet, as well as by total calorie or protein reduction. The likelihood of these measures to prevent or alter the development of atherosclerosis, however, is by no means certain, and similar results can be obtained by means other than dietary, *i.e.*, exercise and hormones.

2. Factors of race, age, sex, genetic background, blood vessel anatomy, presence or absence of associated diabetes or hypertension, and the clotting propensity of the blood, each bears a relationship to human atherosclerosis. Control of only diet, therefore, cannot be expected to achieve results in all cases. The sensible application of practical dietary restrictions, however, including total fat and calorie reduction in the overweight, the substitution of plant for animal oils in the normal diet with reduction of total fat to a low or moderate proportion (20 to 25 per cent), can produce no harm and certainly should be offered to those persons with hereditary backgrounds of atherosclerosis, diabetes, and/or hypertension, to those whose serum cholesterols show persistent, unexplained elevations and to all who inquire for dietary advice.

3. The use of publicized commercial preparations at this time remains a discretionary rather than a scientifically urgent matter. Their value over that of the aforementioned measures has not been sufficiently established. In the final analysis, the physician must (as always) temper enthusiasm with caution, combine clinical experience with common sense, and be guided by the preponderance of sound evidence, which he should continually seek out, evaluate, and apply in the light of his own best judgment.

A bibliographic listing of 32 citations will appear in the authors' reprints. Space does not permit the full list in these pages.

The State Department of Health

Burton M. Cohen, M.D.

Elizabeth

Rauwolfia Whole Root in the Long-Term Treatment of Office Patients with Hypertension

In our fascination with Rauwolfia as a tranquilizer, we sometimes forget that it is a hypotensive drug too—in fact, that was its original use. Dr. Cohen here shows that long-term use is safe and effective, with minimal side effects.

Vakil[1] introduced Rauwolfia to western medicine in 1949, with a report of its successful use in hypertension. He asserted that, in his own experience in several thousand cases, the drug had been safe, even when given continuously for as long as two to five years. Among the many references in the literature to Rauwolfia which have appeared over the next decade, there are several reports of its long-term use,[2,3] but this aspect of treatment may not have received the attention it deserves. In a chronic ailment such as hypertension, which requires months or years of continuous therapy, the safety of the drug on continued administration is of prime importance to the patient and physician.

Over the past three years, I have used a whole root preparation of Rauwolfia serpentina in treating ambulatory patients with hypertension of various degrees of severity. Most of these patients have been treated continuously for at least six months, and some for more than two years. My own results with Rauwolfia whole root, when administered for such protracted periods, supports the experience of Vakil[1] concerning the relative freedom of this drug from serious toxic reactions.

METHODS AND MATERIALS

Treatment Group: A total of 56 patients, who were seen in private practice during the period, May 1, 1955 to April 30, 1958, are included in this study. All were ambulatory. They ranged in age from 28 to 75 years. Twenty-eight of the 56 were female. Hypertension of varying degrees of severity had been present in the majority of the patients for at least five years, in some cases for longer periods ranging up to twenty-five years. In a number of patients, however, the hypertension was of more recent origin (see Table 1). Initial blood pressure readings varied from 160/90 to 230/140.

A number of the patients complained of such hypertensive symptoms as headache, dyspnea, vertigo, chest pain, tinnitus and palpitations. Eight patients had recurrent anginal attacks. In addition to hypertension, diabetes was present in two cases, heart disease in four, hiatus hernia and recurrent urinary infection in one. Alcoholism was a complication in one patient.

Pre-treatment and post-treatment physical examinations, including blood pressure recordings were made of each patient. Examinations

were also made during office visits by the patient throughout the period of therapy. For purposes of study, the patients were divided into four groups according to the severity of the hypertension, classified by the methods of Smithwick [6] (See Table 1).

Administration of the Drug: Whole root Rauwolfia serpentina was administered to these patients, as 100 milligram tablets,‡ in daily doses ranging from 50 to 400 milligrams, for periods given in the following tabulation. Initial doses generally varied from 200 to 300 milligrams (400 milligrams in 7 cases) and the dose was adjusted downward as soon as the response of the patient indicated that the dosage could be lowered.

Period of Treatment	Number of Patients
2 to 5 months	6
6 to 12 months	25
13 to 24 months	21
25 or more months	2

A summary of the results of therapy with Rauwolfia appears in Table 2. In 33 of the

TABLE 1.
THE PATIENTS

Severity of Disease*	Total No. of Patients	Male	Female	Average Age (years)	Average Duration of Illness (years)	Average Duration of Rauwolfia Therapy (months)
Grade I	8	4	4	49 (28-61)	5.2 (.2-15)	6.2 (5-18)
Grade II	28	14	14	54 (34-75)	6.7 (1-22)	12.5 (2.5-26)
Grade III	18	10+	8++	61 (47-76)	8.4 (1-25)	12.3 (4-29)
Grade IV	2	0	2+++	62 (59-66)	6 (5-7)	10.7 (4.5-17)

* According to the classification of Smithwick.[6]
+Diuril® was added to the regimen in 4 cases.
++Diamox® was administered concomitantly with Rauwolfia.
+++Diuril® was added to the regimen.

TABLE 2.
SUMMARY OF RESULTS

Group	Patients	Milligrams Rauwolfia Daily	Duration of Treatment Months	Number Becoming Normotensive	Average Mean Blood Pressure Before	Average Mean Blood Pressure After	Average Mean Fall in Blood Pressure Millimeters
I	8	200 to 300 then 100	5 to 18 Av.=6¼	8	134	108	26
II	28	200 to 400 then 50 to 300	2½ to 26 Av.=26	20	145	114	31
III	18	Same as II above	4 to 29 Av.=12¼	5	157	126	31
IV	2	300	4½ to 17 Av.=10½	0	182	146	36
—	—	————	————	—	——	——	—
Totals	56	50 to 400	12	33			

Notes: The addition of Diuril® to the regimen of 3 Group III patients resulted in further reduction to normotensive levels in all 3 cases. Both Group IV patients also had Diuril® added to the program and their systolic pressures then dropped to 160 and 150 respectively. The "average mean fall" is determined by subtracting the average post-treatment mean from the average pre-treatment mean. The concept of "mean" pressure is explained in the text. In this table, "normotensive" means 150/90 blood pressure or less.

‡We used the Squibb brand, tradenamed as Raudixin®.

TABLE 3.

DISTRIBUTION OF DECLINE IN ARTERIAL PRESSURE FOLLOWING TREATMENT WITH RAUWOLFIA

Fall in Systolic

mm. Hg.	No. of Patients from Groups I	II	III	IV
0	0	0	0	0
1-10	0	1	0	0
11-20	0	2	3	0
21-30	4	2	3	0
31-40	2	13	7	1
41-50	1	6	2	1
51-60	0	2	0	0
61-70	1	0	1	0
70 and over	0	2	2	0
Total	8	28	18	2

Fall in Diastolic

mm. Hg.	No. of Patients from Groups I	II	III	IV
0	0	0	0	0
1-10	5	5	4	0
11-20	3	16	7	0
21-30	0	6	6	2
31-40	0	1	1	0
41-50	0	0	0	0
51-60	0	0	0	0
61-70	0	0	0	0
70 and over	0	0	0	0
Total	8	28	18	2

Mean Fall

mm. Hg.	No. of Patients from Groups I	II	III	IV
0	0	0	0	0
1-10	0	0	0	0
11-20	4	3	4	0
21-30	2	11	8	0
31-40	1	12	4	2
41-50	1	1	2	0
51-60	0	1	0	0
61-70	0	0	0	0
70 and over	0	0	0	0
Total	8	28	18	2

Mean fall is ½ [(pre-treatment systolic + pre-treatment diastolic) - (post-treatment systolic + post-treatment diastolic)].

The subsequent addition of Diuril® to the regimen of 4 patients in Group III and of both patients in Group IV resulted in further declines in blood pressure in these patients.

56 patients, blood pressure declined to normal levels (150/90 or lower). All with Grade I hypertension became normotensive, as did 20 of the 28 with Grade II hypertension. Less satisfactory results were achieved in the more severe cases. Blood pressure levels, however, declined in all cases in this series with a mean fall of at least 11 millimeters, the majority showing a mean fall between 21 to 40 (see Table 3).

One of the most gratifying results of therapy was the symptomatic improvement experienced by the patients (see Table 4). Lessening or relief of the symptoms commonly associated with hypertension, such as headache, vertigo and dyspnea was reported by a number of the patients. Eight patients experienced partial or complete relief of anginal symptoms. A sense of well-being or improvement in "hypertensive symptoms" was reported by 97 per cent of the patients.

TABLE 4.

SYMPTOMATIC RELIEF OF SYMPTOMS

Patients Reporting Alleviation	I	II	III	IV	Total
Angina	0	4	4	0	8
Anxiety	1	2	0	0	3
Backache	0	0	2	0	2
Chest pressure	0	0	3	1	4
Dyspnea	0	5	6	0	11
Fatigue	0	2	2	1	5
Flush	0	2	1	0	3
Headache	5	15	7	0	27
Light-headed	0	0	1	0	1
"Nervousness"	1	2	0	0	3
Palpitations	1	1	2	1	5
"Pressure" (tension)	0	2	1	1	4
Tinnitus	0	0	2	0	2
Vertigo	3	6	7	0	16

SIDE EFFECTS

SIDE effects were reported by 29 of the patients. Those ocurring most frequently were nasal stuffiness and weight gain (see Table 5). These reactions were generally of short duration and responded to symptomatic treatment. Weight gain was the most persistent effect and usually amphetamine was prescribed to control the appetite. The effects

TABLE 5.

INCIDENCE OF SIDE EFFECTS

Side Effect	No. of Patients from Groups I	II	III	IV	Total No. of Patients Reporting Reaction	Remarks
Nasal stuffiness	0	6	5	0	11	Nasal stuffiness lasted from 1 to 4 weeks and responded, in every instance in which treatment was administered. We used a hydrocortisone decongestant, tradenamed Vasocort®.
Loose stools	0	2	1	0	3	There was relief of long-standing constipation in one patient. Aluminum gel was prescribed for another. The third required no treatment.
Weight gain (or inability to lose weight)	2	7	5	0	14	The inability to lose weight was the problem in 4 patients. One required no treatment for weight gain. D-amphetamine was prescribed in 8 cases.
Frequent urination	0	2	0	0	2	
Nightmares	0	0	1	0	1	Patient responded to reduced dosage.

were not sufficiently severe in any case to indicate withdrawal of the drug.

DISCUSSION

RESULTS in this series were indeed gratifying.

A satisfactory lowering of the blood pressure was achieved in the majority of patients with normotensive levels being reached in every case with a mild disease and in 33 (58 per cent) of all those treated. This finding is in accord with the observation of Wilkins[4] that Rauwolfia may be surprisingly efficacious when given alone, even in more severe cases of hypertension. The improvement in hypertensive symptoms reported by practically all of the patients was one of the chief benefits from treatment with Rauwolfia. The partial or complete relief of anginal symptoms during treatment was a particularly desirable result and confirms the observations of Ford and Rochelle.[5] Side effects were annoying but not serious. Their generally mild form and response to symptomatic treatment indicate that, in the dosage given, Rauwolfia may be safely administered continuously for months or years.

SUMMARY AND CONCLUSIONS

A PREPARATION of whole root Rauwolfia serpentina,‡ has been administered to 56 ambulatory hypertensive patients for periods up to 2½ years, in daily doses ranging from 50 to 400 milligrams. Blood pressures declined in all cases and reached normal levels (150/90 or less) in 33 of the 56 patients. Associated symptoms improved in practically all of the patients. Angina was partly or completely relieved in eight patients. Side effects were reported by 29 patients but they were generally mild, responding to symptomatic treatment and in no case necessitated withdrawal of the drug.

The results obtained in this series of patients indicate that whole root Rauwolfia serpentina is a highly satisfactory agent for the prolonged treatment of hypertension. It is safe, effective and usually makes the patient feel better.

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Bibliography will appear in author's reprints.

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Abnormal Uterine Bleeding*

Newer steroid esters are available with progestational action. These products represent a distinct forward step in the treatment of a variety of gynecologic disorders and may be literally lifesaving in cases of habitual or threatened abortion.

The presenting complaint of vaginal bleeding represents a difficult diagnostic and therapeutic problem. Before hormone therapy is instituted, a careful evaluation of causative factors is important. For example, in the menopausal woman the most frequent pathology is anatomical and likely to be cancer. Any delay in diagnosis may readily change the prognosis from favorable to poor. Some understanding of the mechanisms and types of normal and abnormal endometrial bleeding is essential.

There are three essential types of normal endometrial bleeding:

1. Menstruation—Minor variations may be considered abnormal by the patient and presented for treatment.
2. Post-ovulatory bleeding—In a large proportion of women, at least microscopic bleeding may occur as a result of the sudden drop in estrogen levels. The progesterone from the corpus luteum normally checks this.
3. Implantation bleeding—This occurs four weeks from the previous menstrual cycle. It will vary from slight to a flow indistinguishable from normal menstruation.

Abnormal bleeding may be attributed to a variety of causes:

1. Imbalance of pituitary or ovarian hormones.
2. Metabolic disturbances—Metabolic disturbances are frequent in adolescence. Nutritional factors must be evaluated, especially where there has been a sudden gain or loss in weight. Too often, intake of Vitamin B Complex is inadequate, impairing liver metabolism of estrogen. Many teenagers respond promptly to adequate diet and supplementary Vitamin B Complex. Thyroid therapy should be employed only when specifically indicated.
3. Organic lesions, tumors or infection.
4. Blood dyscrasias such as leukemia and purpura.
5. Ectopic pregnancy or threatened abortion.

Diagnostic work-up should be thorough. A complete and accurate case history is necessary to enable careful evaluation of the amount, duration and recurrence of abnormal bleeding. Pelvic examination, complete blood count, metabolic tests to determine metabolic rate, PBI and glucose tolerance, and estimation of estrogen and progesterone sufficiency as well as gonadotropin and 17-ketosteroid levels all contribute to a clear understanding of underlying etiology.

Regulation of Menstrual Cycle

The human menstrual cycle is normally the consequence of a complex interaction involving four anatomical sites—the central nervous system, the anterior pituitary gland, the ovary and the endometrium.

A normal menstrual cycle depends upon the appropriate combination, sequence and timing of these interrelated factors. A specific chain of events was established by Markee[1] in 1939:

1. Arterial growth induced by estrogen
2. Extreme circulatory deprivation
3. Arterial damage
4. Inflow of blood under pressure
5. Arterial rupture

*Read January 12, 1959 at the Staff meeting of the Newark (N.J.) Presbyterian Hospital.

The specific mechanism established by Markee [1] was arterial rupture as a result of the flow of blood under pressure into arteries previously subjected to the effects of ischemia for a period of 2 to 6 days.

OVARIAN HORMONES IN THE MENSTRUAL CYCLE

Both estrogen and progesterone are physiologic requisites to normal menstruation. The estrogen level is minimal during the period of menstrual flow. It rises shortly before the expected time of ovulation and declines during the week preceding the onset of bleeding. The estrogenic hormone stimulates proliferation and, together with progesterone, secretory transformation of the endometrium.

If an ovariectomized female is given a course of estrogen injections, uterine bleeding occurs after cessation of treatment. If estrogen is followed immediately by progesterone, however, bleeding does not occur until the progesterone is discontinued. Progesterone withdrawal bleeding occurs even if estrogen levels are maintained sufficiently to avoid estrogen-withdrawal bleeding. On the other hand, progesterone in sufficient amounts will induce bleeding without immediate or simultaneous treatment with estrogen. The bleeding [2] stimulated by these types of treatment is similar to normal menstruation in amount, duration and local vascular phenomena.[2,3] Bleeding may occur during prolonged administration of constant daily doses of estrogen or if levels of the hormone suddenly drop below a critical point.

Episodes of uterine bleeding are influenced by the components, relative strength, and duration of action of previous hormonal stimuli as well as by the current stimulus.[4] Thus, a single course of stimulation by ovarian hormones is not limited in influence to the immediate cycle but rather extends through at least one subsequent cycle and probably even longer. This influence on the menstrual cycle is mediated partly through the structural changes produced in the endometrial vascular bed. The specific vascular architecture existing at the onset of any single cycle has an important influence on the duration of the uterine bleeding in that cycle.[4]

Progesterone, the active principle of corpus luteum has as its primary function the preparation of the uterus for nidation and maintenance of conditions favorable to pregnancy. It also inhibits uterine contractions and ovulation, prevents estrogen-withdrawal bleeding, promotes progesterone withdrawal bleeding, induces acceleration of protein catabolism and increases excretion of urinary sodium and chlorides. Factors determining the functional span of corpus luteum in the non-pregnant state or controlling the transition from growth to atresia remain unknown. It is known, however, that the duration of action of progesterone is influenced by estrogen levels at the time it is administered.[4]

PROGESTATIONAL AGENTS FOR FUNCTIONAL BLEEDING

Progesterone deficiency has been demonstrated to be an outstanding etiologic factor in functional bleeding. Consequently, the primary objective of therapy is the correction of this lack of ovarian hormone. A continuous supply of progesterone necessary for a normal cycle could in the past be assured only through repeated injection or administration of oral doses 20 times those given parenterally. In both instances, either cost or inconvenience to the patient, sharply limited therapeutic use.

In 1954, Junkmann [5] discovered that both duration and degree of biologic activity were increased by esterification of 17-alpha-hydoxyprogesterone with caproic acid. The resultant 17-alpha-hydroxyprogesterone-17 -n- caproate* exerts a progestational effect at least twice as marked and twice as prolonged as equal amounts of free progesterone given parenterally, and at least 30 times more pronounced and 5 times longer in duration than the parent compound 17-alpha-hydroxyprogesterone. Further investigation disclosed that this ester had no androgenic or anabolic effect in rats.[5]

The duration of action of any progestational agent is significantly influenced by the amount

*Delalutin, E. R. Squibb & Sons.

of estrogen present at the time of its activity. This was confirmed by Boschann [6] in his study of four castrated women. Employing the short-acting estradiol benzoate, he induced bleeding similar to normal menstrual flow between 7 and 11 days following the second of two single injections of 125 milligrams of 17-alpha-hydroxyprogesterone caproate (Delalutin). The second injection of Delalutin® and the final injection of estradiol benzoate were given simultaneously.[7] Davis and Wied [8] demonstrated that by administering the longer-acting estradiol valerate† in a priming dose of 15 to 20 milligrams and later in a dose of 5 milligrams simultaneously with 250 to 375 milligrams of Delalutin® the progestational effect of Delalutin® was evidenced for a period of 14 to 19 days. It does not seem probable that this ester is gradually hydrolized at the injection site since it has been observed to produce secretory changes in the endometrium typical of those seen in the normal menstrual cycle and which are not produced by free progesterone.[8] Delalutin® is also more potent and effective in simulating the diphasic basal body temperature cure of the normally ovulating woman and in causing luteinization of the vaginal cytology.

Recently, two oral progestational preparations have been made available for the treatment of disorders of the menstrual cycle and other gynecologic uses. These are 17-alpha-ethynl-19-nortestosterone‡ and 17-alpha-ethynyl-17-hydroxy-5(10)-estren-3-one to which ethinylestradiol 3-methyl ether has been added.§ When the first is given in 10 milligram doses from the 15th to the 25th day of the cycle to women with an adequate endogenous supply of estrogen, biopsies taken on the 20th to the 22nd day reveal a typical secretory endometrium. If the second preparation is given from the 5th to the 25th day of the cycle, the endometrium shows glands in various stages of secretory exhaustion and is similar in character to the endometrium of early pregnancy. An estrogen compound has been added to the second preparation to prevent break-through bleeding. This combined preparation shows far less progestational effects on vaginal cytology than the nortestosterone compound or Delalutin®.

†Delestrogen, E. R. Squibb & Sons.
‡Norlutin, Parke, Davis & Co., Detroit.
§Enovid, G. D. Searle & Co., Chicago.

PROGESTATIONAL AGENTS FOR OTHER DISORDERS

Recently, at a symposuim on new compounds with progestational activity, independent investigators reported their experiences with these materials in various gynecologic disorders. A review of more significant findings by these and other clinicians is presented here.

Southam [9] used Delalutin®, Norlutin® and Enovid® in 68 women with menstrual abnormalities. All three preparations were found effective in producing cyclic withdrawal bleeding and in preventing recurrent metrorrhagia and of value in amenorrhea as a test of endometrial responsiveness. In 25 patients with infertility problems, pregnancy occurred four times. When these compounds were given after ovulation to 42 patients with inadequate luteal phases, 17 of these conceived. This pregnancy rate was similar to that observed in a control group although untreated patients were followed for a longer period of time. Twenty-four patients with recurrent anovulatory bleeding were treated in the course of this investigation. Ten received Delalutin® without estrogen during episodes of profuse or prolonged bleeding. In 7 instances, bleeding markedly decreased or was arrested for 3 to 10 days prior to the onset of withdrawal bleeding, which lasted 4 to 17 days. In 8 cases, bleeding did not decrease but was stopped in 13 to 16 days by further administration of the drug. In 13 of a group of 15 patients, Norlutin® effectively arrested bleeding and also deferred the onset of withdrawal bleeding.

Investigators for the Worcester Foundation for Experimental Biology and the John Roch Hospital for Women reported on the use of Enovid® by 200 women in Puerto Rico who desired to avoid pregnancy.[10] A 10 milligram dose was administered daily from the 5th to the 25th day of the menstrual cycle. When no doses were missed, there were no

pregnancies in 1,279 cycles. In 151 cases, where more than 5 daily doses were missed there were 3 pregnancies.

Finkler [11] treated 60 women with disturbances in ovarian function. She points out that, to be effective, cyclic steroid therapy must be administered in a regimen which provides hormone levels simulating the endogenous gonadal hormone production so that:

1. The cyclic activity of the anterior pituitary gland is maintained as with normal ovarian function.
2. The sequence of alterations in genital tissues, particularly the endometrium, occurs exactly as with normal ovarian function.
3. The activity of the ovaries themselves is temporarily suppressed allowing glandular tissue to regenerate.

It is essential that an interval of 3 to 4 months without cyclic steroid therapy be introduced into the therapeutic program after the patient has been treated for a period of 3 to 4 months. The interval provides opportunity for the ovary to resume normal function, if this is possible.[11]

The group treated by Finkler was comprised principally of cases of primary and secondary amenorrhea and women with anovulatory cycles. When two injections per month were given, 20 milligrams of estradiol valerate (Delestrogen®) followed in two weeks by 125 milligrams or more of Delalutin®, normal cycles were produced as well as an endometrium which could not be distinguished from that of women with normal cyclic bleeding. Studies involving the anterior pituitary gonadotropic hormone demonstrated that frequently this type of therapeutic schedule resulted in a normal pattern of hormone production.[11]

PROGESTATIONAL AGENTS IN ABORTION

MANY abortions occur in the absence of extrinsic maternal disease or obvious pelvic pathology. Intrinsic factors related to the physiology of conception and implantation of a fertilized ovum must be considered. Some contend that the defect lies in the germ plasm itself, involving a deficient ovum or defective spermatazoa. Based on microscopic findings, it has been estimated that in 60 to 70 per cent of abortions, the ovum is defective.[12]

Shettles [12] points out that studies of early fetal development in patients of proved fertility and normal reproductive history demonstrated that about half of 28 early conceptuses from 136 patients exhibited abnormality. Of 33 ova fertilized *in vivo* and recovered *in vitro* from 158 patients with a normal reproductive history, 30 per cent were so abnormal that abortion was probable before pregnancy became clinically evident. A study of 1497 planned pregnancies in private patients indicated that the incidence of abortion was greatly increased with advanced age, when there was a history of previous abortion, and when there was a history of prolonged sterility. The chance of a defective infant with a woman 45 to 49 years of age is three times greater than with a mother under the age of 30. About 40 per cent of mongoloid children are born after the mother has reached the age of 40. The increase in incidence of abortion in women over 35 years of age has been attributed to older eggs in older women. In women over 44 years of age, it has been suggested that changes in ovarian activity provide unfavorable surroundings damaging to the ovum.

While other clinicians, including Hughes [13] accept these factors, it is felt that pathologic ova may result from an abnormal environment at the site of implantation. Beginning immediately after implantation and extending approximately 120 days until a fully functioning placenta is formed, the nutrition of the embryo is highly dependent upon increasing secretion of estrogen and progesterone which, in turn, stimulate greater metabolic action in the decidua. Many materials, particularly carbohydrates, are metabolized and stored at an accelerated rate and this material can be seen in decidual glands and cells. If the decidua fail to produce enough of the materials necessary for embryonic nutrition, there is a failure in growth which ultimately can be traced back through a complex hormonal pattern to deficiencies in estrogen and progesterone secretion. The deficient secretion of both of these hormones is found in cases of beginning abor-

tion and generally indicates ovular death. The importance of adequate progesterone titers, derived initially from the corpus luteum and later from the placenta, is at no time greater than in this early stage of development.

Reporting on the overall results achieved over a period of two years by 45 groups of investigators who regularly supplied the progestational support of Delalutin® to their cases of habitual abortion, Reifenstein [14] indicated an increase in fetal salvage to 68 per cent in 82 women who in 344 previous pregnancies had a salvage rate of only 11 per cent. The patients given Delalutin® were selected because each had experienced at least three consecutive abortions prior to the pregnancy treated. Best results were obtained when a single injection of 375 to 500 milligrams was given once weekly, starting as early in pregnancy as possible and continuing to within 2 weeks of the expected delivery date.

Another group of 90 women, some with histories of previous abortions and some threatened with abortion or premature labor during a current pregnancy, were given Norlutin® in doses of 5 milligrams twice a day. If pain or bleeding occurred, the dose was doubled. Of the 90 patients, 42 (or 63 per cent) were delivered of living infants while 11 women aborted blighted ova. One hydatid mole and one ectopic pregnancy occurred. Uterine pathology was responsible for 10 abortions. At the time of the report, 23 women had not as yet been delivered.[15]

SELECTION OF PATIENTS FOR PROGESTATIONAL AGENTS

Progestational agents can successfully prevent abortion and undue fetal loss, even in cases with a history of repeated abortion. Selection of patients suited to this type of therapy has been a problem, and is worthy of consideration here.

Kupperman and Lefkovics [16] used as their criterion the fact that the normal pregnant female should excrete 10 milligrams of pregnanediol per month of pregnancy every 24 hours. Patients excreting lower levels of the metabolite were given 1 Gram of progesterone per day by mouth. This method of determining the need for progestational support proved successful in 22 of 28 patients in this series, all of whom had experienced two or more previous abortions. Estimations of pregnanediol levels are costly, however, and sharply limit the applications of this procedure for selection of patients.

It has been suggested [17] that vaginal cytology may serve as a test of viability in those patients threatening to abort. Routine cytology was carried out on a series of 122 consecutive pregnant women, during their first prenatal visit, to detect endocrine dysfunction. Of the 91 clinically normal pregnancies, 11 per cent showed an endocrine deficiency while of the 31 clinically threatened abortions, 55 per cent exhibited evidence of such a deficiency. Where the smear showed evidence of viability, therapy was considered likely to produce a favorable response. On the other hand, no response could be anticipated in patients adjudged nonviable smear types. When more than one-third of the cells in a smear appeared cornified, the smear was considered abnormal. The presence of numerous parabasal and basal cells was also an indication of nonviability.

This method has been adopted as a basis for therapy both at the hospital and in private practice. It is important to undertake cytologic evaluation early in pregnancy, preferably by the second or third week. Therapy is given only when 30 per cent of the cells examined are cornified, regardless of clinical symptoms. Too few cases have been under study thus far for statistical analysis but cytological determination of the need for endocrine therapy in pregnancy appears to have value.

SUMMARY

Steroid esters with progestational action are truly a step forward in the treatment of abnormal uterine bleeding and other gynecologic disorders. In habitual or threatened abortion, administration of these agents significantly reduces the likelihood of fetal loss.

Examination of vaginal cytology appears to

be a practical means of establishing the existence of an endocrine deficiency and the need for an exogenous supply.

Of the progestational agents available, Delalutin® is a potent and long-acting parenteral preparation assuring precise dosage. Norlutin® and Enovid® are oral preparations requiring daily administration. All represent an advance over free progesterone where progestational support is required.

153 Roseville Avenue

Full bibliographic citations appear in Dr. Ward's reprints.

N. J. Student Wins ACCP Prize

The New Jersey Chapter of the American College of Chest Physicians awarded its annual medical students' prize to Mr. Garret M. Keating of New Jersey, a student at Hahnemann. His paper on the management of injuries to the thorax was found to be the best of many excellent manuscripts. The award is made annually. For further details, write to Dr. Emanuel Klosk, 46 Lyons Avenue, Newark 8, N. J.

C. D. Award to Dr. Karel

Dr. Jack R. Karel, a member of our Union County Medical Society, received a citation from the N. J. Department of Defense on May 20, 1959. "Dr. Karel" said the citation "served long hours to provide expert professional services without compensation." Dr. Karel was commander of the 72nd Field Hospital in the Burmese Theatre of Operations during World War II. He has, since his release from active duty, been interested in Civil Defense. He is chairman of the CD Committee of the Union County Medical Society. He is credited with the development of a portable first aid container and with organizing and equipping sites for eight large CD hospitals for emergency use. He has also been active in radiologic defense plans.

Obesity and Pregnancy

This reports a study of 747 mothers,* all weighing over 200 pounds. Eight per cent of them were primiparas and 19 per cent had had eight or more pregnancies. Their mean duration of labor was within normal limits, and 96 per cent had vertex delivery. Spontaneous delivery was more frequent than the average (89 per cent as compared with 78 per cent in the whole obstetrical service) and low forceps less frequent (5 per cent compared with 13 per cent). Cesarean section was done more often (5.2 per cent compared with 3.8 per cent), probably because of the high incidence of disproportion owing to large babies.

There was no increase in maternal or fetal mortality or morbidity. Diabetes mellitus was seen in only 4 patients. At birth 9.5 per cent of the infants weighed 4500 grams or more, compared with 0.6 per cent in the whole obstetrical service. Prematurity occurred in 4.1 per cent of the deliveries in the obese against 15 per cent for the whole obstetrical service.

Toxemia was commonly associated with obesity, its frequency increasing with rising of weight until in the heaviest group no patient was free from it.

*Witten, S. N.: Obstetrics and Gynecology, 12:99 (Dec. 1958)

T. K. Rathmell, M.D.

Trenton

X-Ray Stinginess

Fifth in a series prepared by the Cancer Control Committee of The Medical Society of New Jersey.

There was a time when practitioners of medicine would glibly request radiologic examinations on any portion of the patient's anatomy without giving a second thought to the hazards of such a procedure. Present knowledge, however, teaches us that the hazards of radiation exposure must be reckoned with if we are to offer safe medical practices. Radiation injury, once it has been produced, has at present no known antidote. Radiation damage is an insidious specter which will probably haunt the medical profession in increasing proportions.

The great danger of over-exposure to radiation is the production of mutations. Severe mental damage is probably the greatest mutation burden. However, fortunately or otherwise, the basis for this statement is experimental work on fruit flies and mice.

Congenital malformations may result from exposure to radiation from the second to the eighth week of gestation. Penetrating therapeutic irradiation to the abdomen during pregnancy may cause abortion or stillbirth, as well as a high incidence of developmental anomalies.

Children who have received comparatively low doses of radiation to the neck and chest have been known to develop cancer of the thyroid after a latent period of about seven years. The increased exposure to diagnostic radiation may be one factor contributing to the rising incidence of leukemia in the whole population. This is supported by the finding that the incidence of leukemia among physicians in general is but one-tenth the incidence of leukemia among United States radiologists. In the period from 1948 to 1956, leukemia was the cause of more than 7 per cent of the radiologists' deaths. Cataracts following exposure to radiation in the region of the eye are well authenticated and careful x-ray therapy technic in proximity to the eye minimizes this complication. Few physicians realize that the current enthusiasm for minifilms of the population subjects the individuals to about ten times the dosage of radiation necessary for the production of a routine 14 by 17 inch chest plate.

The physician should help maintain proper perspective in community discussions on radiation hazards. Our exposures to radiation must be minimized, while attempts must be made to get the maximum health benefits from diagnostic radiation. Good radiologic technics consider protection of the doctor, the technician, the patient and neighbors. Physicians who have had no basic training in fluoroscopy or protection technics under a competent radiologist should *not* be utilizing x-ray for diagnosis or therapy. Physicians performing diagnostic x-ray should use the fastest screen, the greatest amount of filtration, the lowest radiation output and the fastest film compatible with good pictures.

In fluoroscopy, an improved image intensifier should be utilized whenever possible. Physicians should not squander the period of dark adaptation preliminary to fluoroscopy in ex-

change for a higher radiation dose on the patient.

Therapeutic irradiation for benign lesions, especially if other methods of therapy are available, should be avoided. Full gonadal protection to both the male and female patient must be a component part of all radiologic examinations.

In general, avoid radiation for arthritis, bursitis, cosmetic problems, acne, or ovarian sterilization. All patients should be questioned concerning their previous exposure to radiation. Unless there are clinical suspicions of abnormalities, short interval serial check-ups after surgery of polyps or of known stomach or duodenal ulcers should be consigned to the trash barrel. Fluoroscopic examination as a routine, without clinical suspicion of disease, is no longer justified.

Increasing age may make radiologic indications more liberal. Any radiation increases the probability of damage but, in general, the younger the patient, the longer will be his hazard. Suggest radiologic examinations in people under thirty years of age only when there are specific, direct and absolute indications for the same.

Legislation cannot solve this problem. If the public becomes educated about the desirability of minimizing radiologic exposure, those practitioners who are not properly trained in the art and fail to utilize modern equipment will gradually be eliminated. The old statement is still true: he who builds a better mouse-trap will eventually catch the most mice.

Reference: Primer on Radiation Hazards for Physicians, R. E. Peterson, J. A. Baron, B. M. Kent, T. C. Evans; Archives of Internal Medicine; 103:152 (1959).

446 Bellevue Avenue

Asthma Death Rate is Rising

This report* is based on 174 cases in which death was caused primarily by bronchial asthma. All cases succumbed during a paroxysm or were found dead shortly thereafter. Excluded were patients known to be sensitive to an allergen administered before death, those who had received sedation, and those in which any complication contributed essentially to death. In all instances autopsy findings confirmed the diagnosis. Material was derived from a survey of the records of over 1500 patients who had entered a hospital primarily for asthma over a period of 32 years, as well as reports from the literature. The following data are submitted:

1. The death rate from asthma has increased since 1925.

2. A progressive rise has occurred in the average age of hospitalized adult asthmatics (from age 35 in 1924 to 50 in 1954) as well as in the average age of onset of asthma (25 in 1925 to 39 in 1954).

3. Seventy-eight per cent of those who die are over 35 years of age.

4. A close parallel was found between the curve of incidence of fatal asthma and that of periarteritis nodosa, with which it is associated.

5. That bronchial asthma may become malignant is indicated by the fact that its duration was less than two years in 37 per cent of the fatal cases and less than five years in 57 per cent.

*L. Alexander of Washington University as reported in *Excerpta Medica*.

Dayton Tyler Kieswetter, M.D.

East Orange

Thyroid Medication for the Excessively Thin Patient

The fat boy of Dickens—lethargic, coarse-skinned, with low metabolism, is not the only prototype of hypothyroidism. Sometimes, as Dr. Kieswetter here shows, hypothyroidism may be manifested by underweight and increased emotional tension. Thyroid proved an effective remedy.

The average physician, when considering problems of abnormal weight, associates obesity with hypothyroidism. He considers hyperthyroidism only when the patient is too thin. Actually, however, the metabolic defects resulting from hypothyroidism can lead to extreme thinness. Remarkable degrees of weight gain can be accomplished by administering thyroid medication to hypothyroid underweight patients. This has been largely overlooked in the literature although descriptions of poor appetite and digestive distress appear in some of the earliest descriptions of hypothyroidism.

The effect of the thyroid gland on the body has been appreciated in some of its aspects for hundreds of years. Galen in *De Voce* in 1543 first described the gland. By 1656 when Wharton gave it its present name, guesses as to its significance were leaving the realm of fantasy and were becoming partly correct. It was not, however, until King [1] in 1836 formulated the concept of an internal secretion that its role in the general metabolism of the body was suspected. Horsley [2] in 1868 was among the first to realize that myxedema might be due to thyroid deficiency. By 1885, thyroid deficiency was a recognized entity and thyroid extract was first used by Howitz.[3] Since then information about the thyroid has rapidly increased, particularly in the last ten years, aided greatly by studies using radioactive iodine.

Thyroid hormone plays a part in the metabolism of virtually all the body cells. The hormone is bound to protein and rather slowly is liberated to enter the cells, probably as free thyroxine. There it is metabolized to triiodothyronine, its active form, and further degraded to iodinated tyrosine which, in turn, is deiodinated enzymatically.[4] When this hormone is grossly deficient in the adult, myxedema results with its familiar features, including fatigue, mental dullness, tendency to obesity, puffy face, thick skin, coarse, brittle hair, constipation, anemia and elevated cholesterol. In this condition the metabolic rate is well below normal and the radioactive iodine studies tend to be low, although normal iodine studies are far from rare in well-established cases.[5] Myxedema is relatively rare, constituting less than 0.08 per cent of hospital admissions.[6]

Lesser degrees of thyroid deficiency are a great deal more common [7] although there is no way to arrive at an exact figure.

Hypothyroidism can occur at any age but generally is in the 30 to 60 age group [4] and is five times more common in females than males.[5] The symptoms of simple hypothyroidism are much less pronounced than in myxedema—so much so that Kimble and Stieglitz [7]

1. King, T. W.: Observations on Thyroid Gland. Guys Hospital, Report, 1:429 (1836).
2. Horsley, V. A.: On the Function of the Thyroid Gland. Proc. Roy. Soc. London, (1868).
3. Howitz, F.: The Treatment of Myxedema by Feeding with Thyroid Glands. Proc. Roy Soc. London, 38:5 (1885).
4. Werner, S. C.: The Thyroid. Hoeber-Harper (1955).
5. Harrison, T. R.: Principles of Internal Medicine. Blakiston (1954)
6. Buxton, C. L., Hermann, W. L.: Effect of Thyroid Therapy on Menstrual Disorders. J.A.M.A., 155:1035 (1954).
7. Kimble, S. T., Stieglitz, E. J.: Hypothyroidism: A Geriatric Problem. Geriatrics, 7:20 (1952).

referred to it as "masked hypothyroidism."

In a simple hypothyroid state, the symptoms are generally vague and non-specific. Fatigue and tendency to sleep long hours are commonly seen, along with headaches, nervous tension and constipation.[9] Mental dullness is not common. Family history is generally of no significance.[8] The *sine qua non* in the diagnosis of this condition is the metabolic rate. According to Werner,[4] 80 per cent of normal people will have metabolic rates between plus ten per cent and minus ten per cent, while the hypothyroid patient without frank myxedema is generally between minus ten per cent and minus twenty-five per cent. Peters and Man [10] report that normal cholesterol values range from 130 to 280, while hypothyroid patients generally are in the 250 to 325 range. The same authors [11] found phospholipids raised as well as the cholesterol in hypothyroid states.

When the metabolic rate is normal and the cholesterol is below 250, hypometabolism from other causes than thyroid deficiency must be considered. Pituitary atrophy, Addison's Disease, eunichoidism, menopause, nephrosis, muscular paralyses and atrophies, long-term cortisone therapy, and anorexia nervosa can all create hypometabolic states.[4] It is in the fields of gynecology and obstetrics [6] that physicians seem most likely to misdiagnose other forms of hypometabolism as hypothyroidism. However, even in these cases, small doses of thyroid are often helpful in treatment.

THE cause of hypothyroidism is not clearly understood when a goiter is not present and the patient has had an adequate iodine intake. Stress can seem to be the cause but this is more often associated with hyperthyroidism [4] than hypothyroidism.

Since thyroid hormone affects most of the cells of the body, poor nutrition can result from a variety of mechanisms. To some extent the defect is at the cellular level, but it is even more directly apparent at the digestive level. Achlorhydria [12] is common and both diminution of intestinal motility and gastric hyperperistalsis [13] have been reported in hypothyroidism. There is evidence that sugars and vitamin A are poorly absorbed in hypothyroidism [14] and perhaps other food elements also.

The poor digestion, absorption and utilization of foods has been advanced as the cause of poor nutrition in hypothyroidism by several authors. Heald and his associates [15] have pointed out that obese adolescents are often wrongly suspected of hypothyroidism while the excessively thin adolescent who matures slowly is rarely appreciated as a thyroid deficiency problem. Starr [16] also commented on the failure of growth and weight gain in children suffering from deficient thyroid.

Adults have also been noted to be underweight due to thyroid deficiency and to have been helped by thyroid therapy. Lerman [17] in his series reported that 59 per cent of his hypothyroid cases were overweight but 13 per cent were appreciably below normal. Plummer,[18] in 200 cases with deficient thyroid, described many who were emaciated and responded well to thyroid medication. Morton [19] noted several in which there was a brief

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8. Ord, W. M.: On Myxedema. Tr. Clin. Soc. London, 15 (1888).

9. Jackson, A. S.: Hypothyroidism. J.A.M.A., 165:2, Sept. 14 (1957).

10. Peters, J. P., Man, E. B.: The Interrelations of Serum Lypids in Normal Persons. J. Clin. Invest., 22:707 (1943).

11. Peters, J. P., Man, E. B.: The Significance of Serum Cholesterol in Thyroid Disease. J. Clin. Invest., 29:1 (1950).

12. Friedenwald, J., Morrison, S.: Gastrointestinal Disturbances Associated with Endocrinopathies. Endocrinology, 17:393 (1933).

13. Bastenie, P. A.: Paralytic Ileus in Severe Hypothyroidism. Lancet, 1:413 (1946).

14. Althausen, T. L., Lockhart, J. C., Soley, M H.: A New Diagnostic Test in Thyroid Disease. Am. Jour. Med. Sci., 199:342 (1940).

15. Heald, F. P., Masland, R. P., Renold, A. E. Gallagher, J. R.: Hypothyroidism in the Adolescent. J.A.M.A., Vol. 162, Sept. 15 (1956).

16. Starr, P.: Diagnosis and Treatment of Hypothyroidism. Post Grad. Med., 17:1 Jan. (1955).

17. Lerman, J.: Cited by Means, J. H.: The Thyroid and its Diseases. 2nd Ed. Lippincott (1948).

18. Plummer, W. A.: Body Weight in Spontaneous Myxedema. Tr. Am. A. Study Goiter, p. 88 (1940).

19. Morton, J. H.: Sodium Liothyronine in Metabolic Insufficiency. J.A.M.A., 165:2, Sept. 14 (1957).

fall in weight when thyroid was started, followed by adequate weight gain. He ascribed this to an initial diuresis of mild edema due to the hypothyroid state.

The following is a brief summary of the important facts of eight cases. In these, a hypothyroid state with poor nutrition and with excessive thinness seems to have responded well to thyroid therapy.

CASE ONE

A 31-year old man was 74 inches tall but weighed only 170 pounds. He was first seen because of an asthma due to sensitivity to dogs. This was cured by removal of the dogs from his household. At that time complete physical examination was normal, and the patient said that he felt well although he had always been underweight.

He was seen again a year and one-half later, at which time he had lost 8 pounds. He reported "nervous tension" and "poor energy." He complained of vague indigestion, fatigue and a tendency to constipation. These symptoms had existed for several months. Complete physical examination was normal in all respects. Past medical history revealed a story of rheumatic fever at the age of five and scarlet fever at the age of twenty, but there were no evidences of any permanent effect of these illnesses.

Complete blood count, sedimentation rate, serology, urinalysis, chest x-ray and electrocardiograms were all normal. Cholesterol was 372. Liver function tests, heterophile antibody tests, glucose tolerance tests, were all normal. Basal metabolism was minus 22. He was started on thyroid grain one-half, and was continued on this dosage along with vitamins. He rapidly lost all of his symptoms and started to gain weight. This weight gain continued until he reached 200 pounds, at which time he was advised to restrict his diet to avoid further gain. BMR repeated four months after the start of thyroid therapy was plus 9. After one year, he abandoned medication altogether and has remained essentially well for the last year and one-half.

CASE TWO

A thin, quiet young man complained of being underweight. He was anxious and "nervous." He was seventeen years of age, 71 inches tall, and weighed 146 pounds. His mother reported that he seemed perpetually fatigued, sleepy and unwilling to enter into normal social activities. These complaints had existed for four years.

Physical examination was normal in all respects. There was no coarse hair, thick skin, edema nor slow mentality. Chest x-ray was normal. Complete blood count, sedimentation rate, serology and urinalysis were all normal. Metabolic rate was minus 14. Cholesterol was 244.

He was started on one-half grain thyroid daily and gained twenty pounds during the next year. His metabolism was found to be minus one, eight months after starting thyroid. During this time there was also a complete change in his energy and personality. He became energetic and friendly. His school marks conspicuously improved. He has continued for the last year on one-half grain of thyroid, is doing very well, and continues to gain weight although his height has not increased.

CASE THREE

This thirty-eight year old man weighed 116 pounds. He was 69 inches tall. His complaints were underweight and "lack of pep." He had suffered from these complaints for many years along with constipation and a slight "tendency to nervous tension." He reported that he slept a great deal although his sleep was somewhat restless and not refreshing.

Complete physical examination was normal. There was no evidence of goiter and nothing to suggest unusually coarse hair, thick skin or puffy face. Chest x-ray was normal. Complete blood count, sedimentation rate, serology and urinalysis were all normal. Metabolic rate was minus 16. He was started on desiccated thyroid one grain daily and multiple vitamins. He was continued on this for three months during which time his weight increased from 116 pounds to 134 pounds. At this point the thyroid was raised to two grains daily as a matter of scientific interest, although the patient was completely free of all symptoms and stated that he felt "wonderfully well." After two weeks on the two-grain dose of thyroid, he developed considerable nervous tension and the medication had to be stopped entirely for two weeks. Thereafter, he resumed one grain of thyroid daily and continued to show a steady gain in weight. One year after starting on thyroid medication his weight had increased forty-two pounds to 158 pounds, at which time he was instructed to curtail his diet in order to avoid obesity. He has since continued one grain of thyroid and has continued to maintain his weight near 160 pounds and has enjoyed good energy. He states that he now feels somewhat less nervous but continues to have a tendency to constipation.

CASE FOUR

This thirty-seven year old man complained of underweight and jitteriness and a lack of adequate energy. He weighed 141 pounds and was 74 inches tall. He stated that in all other respects he had felt fine for many years. He had had a spontaneous pneumothorax one year earlier, but otherwise had no serious illnesses since childhood.

Physical examination revealed a tall, very thin man, who appeared somewhat restless but was otherwise normal in all respects. Complete physical examination failed to reveal any abnormality. Complete blood count, sedimentation rate, serology

and urinalysis were all normal. Electrocardiogram was normal. Chest x-ray was normal. No goiter was present and there was no evidence of coarse hair, thick skin, or edema. Blood cholesterol was 325. Metabolic rate was minus 23. The patient was started on one-half grain of thyroid which was shortly increased to one grain. On this, he slowly gained weight from 141 pounds to 161 pounds one year later. This was the first time in the patient's memory that his weight had changed more than three pounds in one year. He reported he felt somewhat less nervous and had better energy. Metabolic rate six weeks after starting medication was minus 13 and one year later was plus 8 while still on thyroid.

CASE FIVE

This small, sixty-four year old woman was first seen because of weakness, drowsiness, depression, "nervousness" and a weight loss over the previous two years from her normal of 127 pounds to 112 pounds. She had been well until two years before her first visit, when her symptoms slowly began to develop. She also developed a tendency to constipation. Systems review was negative except for the complaints noted. Past medical history was not contributory.

Physical examination disclosed a thin, worried, anxious woman with a slight parkinson-type tremor of the right hand. Examination was otherwise completely normal. She showed no tendency to coarse hair, thick skin or facial edema. Complete blood count, sedimentation rate, urinalysis, electrocardiogram and chest x-ray were all normal. Cholesterol was 350. Metabolic rate was minus 13. She was started on 25 milligrams of liothyronine,† which was shortly increased to 37½ milligrams per day. On this medication she made slow but steady progress so that at the end of three months she had lost all of her symptoms except a slight residual tendency to nervousness. Her weight slowly increased from 112 pounds back to her normal of 127 pounds. By the end of one year, her metabolic rate was minus 5. During this period the residual nervousness also disappeared and for the last year, while on liothyronine† 25 milligrams daily, she has felt normal in all respects.

CASE SIX

This tall, thin, 35-year old man came in complaining of being nervous and emotional and bothered considerably by easy fatigability and heartburn. He was 74 inches tall and weighed 170 pounds. He stated that these problems had developed slowly over a period of a year before his first visit. Symptoms had followed shortly after his recovery from infectious hepatitis, but were not similar to the symptoms he had experienced with the hepatitis.

Sytems review was otherwise negative and past medical history was not contributory. The patient said that he had at one time weighed 209 pounds, but that he had lost weight during the previous year, to about 170 pounds.

Physical examination showed a 74-inch, thirty-five year old man weighing 170 pounds. Otherwise, physical examination was completely normal. Complete blood count, sedimentation rate, serology, urinalysis, electrocardiogram and x-ray of chest were all essentially normal. Cholesterol was 239. Cephalin flocculation and thymol turbidity tests were normal. Metabolic rate was minus 33. He was started on one-half grain thyroid and this was shortly increased to one grain. However, for the first month of therapy he made very little improvement. Metabolic rate at the end of one month was minus 22. Therefore, his thyroid was increased to two grains daily and on this dose he made a rather steady recovery from all his symptoms over the next five months. During this time he gained from 170 pounds to 185 pounds. He continued the thyroid medication for another year after all his symptoms had disappeared, but then stopped the medicine and has shown no tendency to regression in the past year and one-half.

CASE SEVEN

This man complained of being nervous and "high-strung." He reported that he had been this way for several years but had otherwise always been in good health. He was 35 years old, 76 inches tall, and weighed 173 pounds. Past medical history and systems review were not remarkable. Except for his thinness, he showed a completely normal examination. Blood count, sedimentation rate, serology and urinalysis were all completely normal. Chest x-ray and electrocardiogram were normal. Glucose tolerance test was normal. Cholesterol was 267. Metabolic rate was minus 37. He was started on one grain of desiccated thyroid and vitamins. On this medication he gained 18 pounds in the next year, and within two years of the time he started the thyroid, his weight had risen from 173 pounds to 208 pounds. Shortly after starting on the medication virtually all of his tendency to nervousness disappeared. Re-check BMR was plus 14 but there was no clinical evidence of hyperthyroidism so he was continued on thyroid medication. Over the subsequent years he has remained in excellent health with a weight of around 208 pounds. After four years on thyroid medication he stopped for three months, but did not feel as well and has since resumed the medication.

CASE EIGHT

This tall man was first seen ten years ago, at which time he complained of inability to gain weight, fatigue, and "nervous tension." He also stated that he was doing poorly at his job, although he could not quite understand why. Otherwise he had no complaints. He gave no past medical history of any consequence. He said that he

†Liothyronine is a synthetic thyroid-like substance marketted by Smith Kline and French under their trade name of Cytomel®.

had always been underweight all his life, with a "tendency to nervous tension," and had done relatively poorly in school. He was 34 years old, 77½ inches tall and weighed 170 pounds.

Complete examination was normal. The patient showed no evidence of goiter, coarse hair, thick skin or edema. Blood count, sedimentation rate, serology and urinalysis were all normal. His metabolic rate was minus 15. He was started on thyroid grain one-half, and at the end of two months weighed 173 pounds, and stated that he felt much better in terms of energy, decreasing nervousness and better success at his job.

He was not seen again until two years ago, when he came in weighing 170 pounds, and with more or less the same complaints. He had not had thyroid in the intervening period. Physical examination was normal. Electrocardiogram was normal. Metabolic rate was minus 25. Cholesterol was 299. He was started again on one-half grain thyroid which he has continued since that time. In a month or so, he again reported much improvement in his energy, a decreasing nervousness, and a sense of well-being. He has had over the last two years, more advancement in his business than he had had in the previous ten years. His weight has tended to rise. Although he now weighs 188 pounds, he still remains appreciably underweight for his height.

These cases are of particular interest since they demonstrate hypometabolic states due to a thyroid deficiency in which underweight was a prominent factor. Thyroid medication led to weight gain in all cases and in some cases the weight gain was of truly astounding proportions. With one exception, all these patients were males, ranging in age from 17 to 42. Five of the seven men were six foot-two or taller. All were underweight. All had "nervous tension" and jitteriness which are generally thought to be signs of hyperthyroidism rather than hypothyroidism. There were no other findings or symptoms suggestive of hypothyroidism which were common to all of these patients. None of them showed any particular tendency to coarse hair, thick skin or facial edema. Mental dullness was not an outstanding feature in any although they all seemed to show some increased brightness after therapy with thyroid medication. This brightness, however, could be accounted for on the basis of a general increase in the sense of well-being.

Cholesterol was generally found to be somewhat elevated. In six of the eight cases recheck metabolic rate indicated considerable improvement of the hypothyroidism. In no case was the radioactive iodine uptake or protein-bound iodine studied. It is realized that some of these have not been clearly proved to be hypothyroid cases but merely hypometabolism cases. However, the efficacy of the thyroid medication strongly suggests that the cause of the illness was in fact, too little thyroid secretion in all of them. The rise of the metabolic rate when re-checked supports this belief.

Some of these patients continued on thyroid over a considerable period of time. Some abandoned thyroid without showing a tendency to revert to the previous underweight "nervous" state. This suggests that the hypothyroid state was only of a temporary nature. It is probable that hypothyroid patients with associated thinness are much more common than is generally appreciated.

SUMMARY

EIGHT cases of hypothyroidism have been presented in which rather marked thinness was an outstanding feature and in which the administration of thyroid medication helped the patients to gain considerable amounts of weight. It is suggested that this type of case is probably fairly common and will be appreciated more often if the clinician will keep in mind the possibility of hypothyroidism causing unusual thinness.

75 Prospect Street

A. M. Sophocles, M.D.

Trenton

Microsurgery of Hearing

To prescribe a hearing aid is a quick solution to the patient with failing hearing. But sometimes, as Dr. Sophocles here points out, the basic difficulty can be corrected by surgery—often surgery of such fineness as to justify the title, microsurgery.

Surgery for the restoration and preservation of hearing is limited to the correction of conductive deafness. This includes otosclerosis and inflammatory diseases affecting the middle ear, as well as obstruction of the external ear so as to inhibit or impair conduction of sound from the outside to the inner ear. Otologic surgeons up to 1900 were concerned chiefly with the control of infections in the ear. Surgery directly affecting the ear was either myringotomy, simple mastoidectomy, or radical mastoidectomy. These operations have proved their value and need no discussion at this time.

By the end of the 19th century the literature was reflecting newer approaches to hearing problems. A number of surgeons attempted the first equivalent of stapes mobilization in an effort to extract the stapes from fixation which was then recognized as causing a serious type of deafness. The approach was transtympanic by a myringotomy and soon had to be given up because of the high rates of failures, primarily due to infections.

Between 1911 and 1930 such surgeons as Barany, Holmgen, Sourdille developed the fenestration operation. Lempert has gone on to develop this operation to a point where his technics are accepted by most otologists as the foundation of microsurgery of the ear. This is the phrase we use to identify surgery done under magnification.

In 1952 Rosen brought back stapes mobilization by an original technic with a better approach and better instruments.

OTOSCLEROSIS

Two million people in the United States have otosclerosis. It is twice as common in women as in men. Pregnancy seems to bring out or aggravate already existing otosclerosis. Hormonal and vascular changes are suspected underlying causes although no one factor has yet been demonstrated as clearly responsible.

PATHOLOGY

Abnormal bone deposits occur around the oval window fixing the stapes footplate so as to immobilize the conduction apparatus. This is characteristically a progressive type of deafness. As the stapes becomes more fixed, air conduction loss reaches up to 65 per cent. Eventually nerve degeneration may set in and the symptoms of tinnitus and vertigo may develop. The deafness may then increase beyond help.

STAPES MOBILIZATION

This operation is done under local anesthesia. The tympanic membrane is lifted by an incision in the posterior canal wall and then

folded forward to expose the ossicular chain. The ossicles are not always seen until the removal of a shelf of bone from the posterior canal wall. When the stapes is first seen it may be mobilized by applying pressure to it by probe to the incudo-stapedial junction. Success at this stage is an ideal solution. The stapes suddenly becomes loose, the patient experiences some vertigo, and hearing tests show immediate improvement of hearing.

Should the first attempt fail, pressure is then applied to other points on the stapes itself and especially at its footplate. If mobilization by pressure fails, Rosen advocates fenestration of the footplate. This is not accepted by all otologists.

The procedure as a whole is now widely accepted. Results over the last five years have progressed from an original of 30 per cent success to a current report of 75 per cent of early successes, and final results at 50 per cent.

Some cases will not yield to mobilization. In other patients, the area closes after successful mobilization. We cannot account for the delayed failures—which occur in about one third of the early successes. One factor is the adhesive effect of respiratory infections resulting in otitis media. Should closure of a mobilized ear occur, we may attempt remobilization; or we may resort to the fenestration operation which many otologists prefer to leave as second choice.

Instruments are constantly being improved. With each such improvement, more successes are reported, including better visualization as by the development and increasing use of the operating microscope.

FENESTRATION

THE pathology again is that of otosclerosis. The success rate here is higher than in stapes mobilization, going up to 95 per cent.* Its course is more predictable than that of the mobilization. A certain number will eventually close again by regrowth of bone or fibrous tissue. The technic of the procedure keeps down bone regrowth and insures more lasting success. Infections, however, will undo the success of many well fenestrated ears and delayed failures are unpredictable.

The surgery in fenestration is essentially as follows. A mastoidectomy exposes the lateral horizontal canal. The tympanic membrane is preserved and a skin flap is also preserved in continuity with it. A window is created at the anterior end of the horizontal canal and the membranous labyrinth is carefully preserved. The skin flap is placed over the fenestrum and tightly sealed over it by packing. The incision, which is usually an endaural one, is closed and, a few days to a few weeks later the ear is hearing again, if the operation is successful.

FUNCTIONAL RESTORATION

THE amount of hearing restored in both of these operations depends on the condition of the auditory nerve. If it has not suffered degeneration, in the majority of cases we may expect hearing to return to between 10 and 25 decibels' loss in the mobilization of the stapes. In fenestration it often returns to about 25 decibels if the operation is entirely successful. In either case this is serviceable hearing and quite an improvement for the average otosclerotic.

INFLAMMATORY DISEASES

HERE we deal with the results of infection binding down the oval and round windows or just the conductive apparatus external to these windows. The area should first be free of exudation so that an absolutely dry field can be entered for reconstructive surgery.

TYMPANOPLASTY

THIS is a newer operation developed in Europe in the last three years. It is widely studied and applied in the United States. It

*Many local otologists report that this figure is too high.—Editor.

attempts to correct every type of defect in the conductive apparatus from a perforation of the tympanic membrane to a middle ear full of granulations with destroyed ossicular chain and adhesions binding down the oval and round windows. The pathology extends from otitis media to chronic mastoiditis with cholesteatoma. The tympanoplastic procedures now try to replace the radical mastoidectomy with careful dissection, removing diseased bone and granulations. When the oval and round windows are tightly sealed by adhesions, the procedure calls for thorough removal of adhesions, placing a skin graft over the middle ear so as to create a new drum. Fine microsurgery and good understanding of physiology are required. New tympanic membranes and middle ears are thus created, some with the ossicular chain intact, restoring hearing to normal; others have the tympanic membrane placed against the medial wall of the middle ear in such a way as to keep the Eustachian tube open and at the same time keep the oval and round window phase difference so as to prevent sound neutralization.

SUMMARY

THIS sketchy review of recent otologic surgery is intended to acquaint the practitioner with modern trends. As long as there is a healthy cochlea with its central connections, we owe it to the patient to attempt to preserve it. Otosclerosis and inflammatory disease of the middle ear are not static. At first they appear as mild degrees of deafness and the most benign perforations become the seat of destructive mastoiditis. The otosclerotic patient may be quite comfortable at first with a hearing aid. Eventually he may find himself with severe nerve involvement to the point where hearing aids are of no help. It is encouraging, however, that as many as 30 per cent of otosclerotics do not suffer nerve degeneration, even in advanced cases.

The physician who first sees the patient with hearing problems often refers him to a Hearing Center. Unfortunately some Hearing Centers are partial to the use of hearing aids rather than to correction of the underlying problem. Some are outright shops for the sale of such aids. Others are staffed by well trained audiologists who become overzealous in trying to bring about a quick solution to the problem. Forgetting that the ear has anatomic, physiologic, and pathologic aspects, they know only what the audiogram tells them. Before recommending a hearing aid, the more enlightened audiologists will consult the otologist.

Today's microsurgery of the ear is becoming available everywhere in large and small hospitals throughout the world. It is the hope of the otologist that the clinician who first sees deafness will remember that we now have in our hands some means of correcting the basic problems underlying certain types of deafness. If the type of deafness is not clear to the practitioner, the otologist should be asked to study the patient and to determine his future course of action.

224 West State Street

Diabetic Syringe for Blind

A simple, inexpensive syringe holder that enables the blind diabetic to be completely independent in administering his insulin has been designed by Ethel Turner, R. N., of Baltimore, with the help of an engineer. The holder has a slide and stop that can be locked in any desired position to measure a specific dose. By touch alone the blind diabetic can adjust the holder for the required dose of insulin.—*The American Journal of Nursing*, May, 1958.

Samuel H. Sherman, M.D.*

Newark

Care of Veterans by the Private Practitioner

Here is a practical compendium of procedure for the private practice care of veterans under VA auspices. If you do not bind your Journals, *cut out these pages and keep them handy for swift reference.*

Veterans who were discharged or retired under honorable conditions may be entitled to treatment for service connected disabilities. Service connection must be formally established by the Veterans Administration.

Conditions aggravated by or adjunct to a service connected disability may also make the veteran eligible for authorized treatment when approved by the Veterans Administration.

Spanish American War Veterans and disabled veterans undergoing vocational rehabilitation training may be furnished authorized outpatient care, regardless of the status of service connection. However, the Veterans Administration must establish in each case the legal eligibility of veterans for such care before authorization will be issued.

CHOICE OF PHYSICIAN

If the Veterans Administration determines that examination or treatment will be furnished on a fee basis, the veteran may choose any qualified physician who practices in the community in which he resides. The Veterans Administration will never recommend a specific physician. However, if the veteran requests information as to available physicians in a particular community, the V. A. Regional Office will furnish him with a list. This roster will include at least three practitioners in the community. The veteran will then make his own choice.

REQUEST FOR TREATMENT

The Chief Medical Officer may approve fee basis care by the physician chosen by the veteran or it may be determined that the veteran will receive his treatment at the nearest VA Clinic. *Outpatient treatment should not be given before authorization has been received* in the physician's office unless emergency or prompt treatment is necessary.

INITIAL TREATMENT

Routine original requests are usually made by the veterans themselves on an application form called "Application for Outpatient Treatment." These will be processed by the Veterans Administration as expeditiously as possible and the veteran advised as to whether treatment will be authorized on fee basis or at a VA Clinic. The Veterans Administration reserves the right at all times to examine the veteran to determine his present need for outpatient treatment.

*Chief Medical Officer, Newark Regional Office of Veterans Administration.

EMERGENCY OR PROMPT TREATMENT

EMERGENCY or prompt treatment required for care of acute conditions may be authorized retroactively if requested within 15 days from date of initial treatment. Emergency requests from any part of New Jersey may be made by physicians by letter, postcard, telegram or telephone to the Chief Medical Officer (MArket 3-6800), Newark office. In extreme emergencies, collect telephone calls from *physicians* will be accepted from telephone areas outside the local dial region. Requests should specify the date of first treatment, the number of treatments (home or office) required, and the necessary laboratory studies, x-rays, and so on, as well as diagnosis and recommendations.

CONTINUING TREATMENT

ROUTINE treatment under an established course of therapy must be requested in advance, preferably 10 days prior to expiration of the current authorization period. Forms for this purpose will be furnished to physicians with current authorizations.

The designation of "Long Term Outpatients" is applicable to veterans who will require long term medical care and whose continuing treatment requirements can be forecast within reasonable limits. For such selected cases the Veterans Administration will issue one authorization to render treatment, for as long as one year, but not extending beyond June 30 of any year. Specific information concerning clinical reports, unanticipated medical services, decrease in anticipated medical services and preparation of invoices is included on each such authorization which is issued by the V.A.

PHYSICIAN'S REPORT OF TREATMENT

THE physician's report of treatment becomes a permanent part of the veteran's medical history. The report may have a bearing on future claims for VA benefits. It is a guide for future treatment especially if the veteran should be hospitalized or move to another locality. Therefore, the report should include specific clinical information applicable to the disability being treated, such as, the dosage and name of drugs prescribed, results of laboratory tests (including negative findings, blood pressure readings, loss or gain of weight, units of x-ray, etc.), and prognosis. Informal information and recommendations having to do with the veteran's general welfare, environmental conflicts, need for hospitalization, and the like will be appreciated and may be of value to the Veterans Administration in fulfilling their responsibility to the veteran. All reports should give the dates of findings, treatment and diagnosis. Do not use ditto marks as an indication of repetitive treatment. Please avoid one word summary phraseology as indicative of condition or treatment. These reports should be submitted at the end of the authorization period for regularly authorized cases. With regard to "long term" patients, reports are required once every three months. Only one copy of the report need be submitted. Based upon professional review, inadequate reports will be returned for correction.

INVOICES FOR SERVICES

INVOICES for long term patients should be submitted promptly at the end of each month. All other invoices should be submitted promptly at the end of the period of service unless otherwise specifically indicated in the authorization. These invoices should be addressed to the Chief Medical Officer, Veterans Administration Regional Office, 20 Washington Place, Newark 2, New Jersey. To process the invoice in the Veterans Administration, the dates upon which services were furnished, the proper itemization of such services as authorized and the fees charged *must be shown* on the statement. The invoice may be submitted on the physician's letterhead or billhead, in a single copy, for each VA beneficiary or other individual authorized medical care. No signature or certification is required on the invoice.

Authorization for treatment also embodies

authorization for the furnishing of such medication and other necessary supplies that may be required in the proper care of the veteran. Physicians may prescribe in accordance with their normal practice where such medications or supplies are required in connection with the specific disabilities which they have been authorized to treat. Where the medication is required immediately, the veteran may be directed to procure such prescriptions at local drug stores which are participating in the contract between the Veterans Administration and the New Jersey Pharmaceutical Association. In the case of routine prescriptions for chronic continuing conditions, the veteran may be instructed to forward such prescriptions to the Veterans Administration Pharmacy at the VA Regional Office in Newark.

Whether such prescriptions are filled by participating pharmacies or a VA pharmacy, such medications and/or supplies will be furnished without cost to the veterans. These prescriptions may be written *only* during the validity period of the authorization and for medication related to the treatment of the authorized service connected disabilities.

HOSPITALIZATION

IF HOSPITALIZATION is required for a veteran-beneficiary, the physician should complete an application for hospitalization, form 10-P-10 and send it to the Chief Medical Officer, Veterans Administration Regional Office, 20 Washington Place, Newark 2, N. J., if such hospitalization is for non-emergent condition. If the condition is emergent the physician should call the Admitting Medical Officer at the nearest VA Hospital and discuss the need for such care with that physician. If the condition is such that immediate hospitalization is required and that transportation of the veteran to a VA Hospital would be hazardous to his life, or if no bed is available in a VA Hospital, hospitalization may be arranged in a private hospital. Authorization will be issued in such instances only for *emergency service connected disabilities.* The attending physician must communicate with the Chief Medical Officer at the Veterans Administration within *72* hours of admission to advise of the emergent requirement for such admission. Physicians are encouraged to call the Chief Medical Officer concerning any problems relative to hospitalization.

20 Washington Place

VA STATIONS AND TELEPHONE NUMBERS

N. J. Regional Office—MArket 3-6800
VA Hospital, East Orange, N. J.—ORange 6-1000
VA Hospital, Lyons, N. J.—MIllington 7-0180
VA Hospital, New York, N. Y.—MUrray Hill 6-7500
VA Hospital, Brooklyn, N. Y.—TErrace 6-6600
VA Hospital, Bronx, N. Y.—LUdlow 4-9000
VA Hospital, Philadelphia, Pa.—EVergreen 2-2400
VA Hospital, Wilmington, Del.—WYman 4-2511

Reducing and False Teeth

Patients should be told that reducing will affect the fit of their dentures, reports Dr. S. W. Siljan of Wallace, Idaho. A "blitz" diet does bring about a systemic disturbance that will affect the fit of dentures; however, the change may not be too pronounced if the patient is reducing under the supervision of a physician.—*Dental Survey, June,* 1958.

Andrew Kallos, M.D.

Kearny

Tinea Capitis

In this era of chronic and untreatable diseases, it is well to have a paper now and then on some disorder to which the word "cured" can be applied. Here is a compact, up-to-date monograph on a common medical problem.

Infectious diseases, like styles, have their vogue. Some hold to the fore over a long period; others sink into oblivion after a short reign and may reappear following an eclipse. But, while artists are actively engineering the passing or the revival of fashions, medical men wage an incessant if passive battle against existing or recurring plagues which run their unpredictable courses. Tinea capitis, one of the lesser plagues, has been with humanity since time immemorial. It is well worth the effort to remind ourselves of its persistence. Timely reappraisal of the disease will serve as a guide in recognizing it and as a renewed stimulus in the fight to eliminate it.

In spite of all progress made during the past decade, tinea capitis continues to remain endemic in many sections of the United States. The infection continues to gain momentum and to assume epidemic proportions in countless metropolitan and rural areas. Believe it or not, there is simply no way to establish the true incidence of tinea capitis since, in most places, it is not a reportable disease.

Whether emerging as an isolated case or involving a large group, the clinical appearance of the disease ranges from the "gray patch" to the "pyoderma like sore." A persistent scaly area, a number of broken off hair, erythema, crusting of various degrees, alone or in combination characterize the first group. Massive swelling, boggy surface, thick purulent discharge, enlargement of the regional nodes attest to the acuteness of the condition in the second group. Permanent loss of hair due to scarring (the only sequela of tinea capitis) occurs in a very few of the pyoderma cases. Mild cases are asymptomatic, though itching is occasionally present; there is intense tenderness or pain at the site of the infection and in the lymph nodes in the severe cases. Then, one may see the "intermediary type" where signs and symptoms warrant a subacute classification of the condition.

Microsporum canis, the animal parasite, stays with us at all times and is carried by the cat and dog. It is the most common cause of tinea capitis in our part of the country. Microsporum Audouini has remained, with few exceptions, confined to man. It is propagated from person to person. This latter species causes epidemics in our communities. In recent years Trichophyton Tonsurans infections have appeared in New Jersey. This organism, endemic in the Central Americas and Puerto Rico, was first introduced into southern United States. It took little time to make serious inroads into the more thickly populated northern areas of the nation. Attention must be called to this ringworm of the scalp.

Inanimate objects may serve as vectors in the transmission of the disease. Spores are picked up from toilet articles, from the back of seats in homes, theaters and barbers' shops.[1]

1. Schwartz, L., *et al.*: Ringworm of the Scalp Among School Children. Journal of A. M. A., 132:58 (Sept. 14, 1946).

Most scalp ringworm is found in children between the ages of 5 and 7. They meet with one of the many health hazards in the first grades of school, when their respect for hygiene is still wanting and their instinct to avoid contagion has not been alerted. They become easy prey to the first onslaught by the tiny spores. We have to be thankful, though, in speaking of the risk of tinea capitis instead of a tuberculous infection, a risk that children were widely sharing in the same phase of community life not so long ago.

THE high incidence of the disease in boys in contrast to its low incidence in girls is striking. Hormonal differences between the sexes are minimal, if any, in this early age group. Why the sex difference? Boys frequently interchange caps which exert friction and pressure over the occiput and temples, locations where the infection usually sets in. Boys are more active in sports. They perspire profusely under their caps. The combination of friction and moisture creates an ideal terrain for the fungus. The greater physical activities expose them to frequent bodily contacts with one another, facilitating the dissemination of the disease. The head rest and the clipper in the barber's shop are agents of transmission belonging exclusively to the male sex.

Girls have long hair which leaves only the parting line exposed, throwing up a wall of protection between the threatening fungus and the vulnerable scalp. Girls are possessed, in addition, by an instinct* for beauty; they wash their hair to retain its softness; they brush their hair to retain its luster; they comb their hair to retain its neat setting. In short, they practice better hygiene.

Individual susceptibility to fungus infection is high in the scalp, even if second to that of the bare skin. Scalp infection is often found in several members of a household. The rule is that a good many siblings, preponderantly male, and occasionally one of the parents become infected. But, because of the varying degrees in susceptibility, in spite of the identity of the infecting agent, some escape the infection. Others undergo spontaneous cure. The infectiousness of the human fungus, Microsporum Audouini, is rather low. But the risk of contracting it is high, since the sufferer with this type of ringworm of the scalp harbors the infection over a longer period of time.

*Instinct or a learned interest?—Editor.

DIAGNOSIS

IN CHILDREN, the Wood's light is the simplest and swiftest means of detecting a ringworm infection. Beautiful green fluorescence is present in cases of Microsporum Audouini and Microsporum Canis. Washing and local applications may temporarily suppress this phenomenon, but the infected hair will reveal fluorescence below the skin level after extraction. A less common Microsporum, Microsporum Gypseum, may or may not induce fluorescence in the invaded hair. Apart from Trichophyton Schoenleini (favus), a very rare occurrence in the Western Hemisphere, trichophyta fail to bring on fluorescence in the infected hair. Infection of the scalp with Trichophyton Violaceum, Gypseum and Rubrum is seldom seen in the United States. It is in the steadily spreading Trichophyton Tonsurans infections of the scalp that this lack of fluorescence creates a major concern to the physician. It is hard to spot these nonfluorescent infections and, by the same token, it is hard to watch their course. The diagnosis of Trichophyton Tonsurans scalp infection must be made through the microscope which shows the spores within (endospores) and without (ectospores) the hair shaft and through the inoculation of culture media with the infected hair in the infrequent cases where the direct examination remains inconclusive. In the infections with the Microspora, microscope and culture media are used to confirm a diagnosis already strongly suspected by the Wood's light examination, and to identify the species.

The clinical picture depends on the sensitizing ability of the fungus and on the immunologic response of the host. Pathogenically, animal fungi, Microsporum Canis, Micro-

sporum Gypseum, Trichophyton Gypseum induce a strong focal reaction. Circulating antibodies can be demonstrated by a positive intradermic test; here, the body's defenses overcome the fungus leading to an early recovery from the disease. An inflammatory response in the face of an infection with non-sensitizing fungi may be produced by the nonspecific antigens of the properdin system.[2] Human fungi, Microsporum Audouini, Trichophyton Rubrum belonging to the non-sensitizing category elicit such a nonspecific response, if any, from the human host and fail to give a positive intradermic test; here, the disease runs a protracted course. A subacute clinical picture accompanied by an inconsistently positive humoral reaction characterizes scalp infections caused by Trichophyton Tonsurans, placing it into an intermediary group; here, unfortunately, the course tends to be chronic.

Histologically, the fungus invades the scalp first and spreads through the follicle to the hair shaft subsequently. In the later chronic stage, when the scalp becomes refractory to the penetration of the fungus, the spores may spread from hair to hair.[3] Interestingly, allergic as well as nonspecific reactions in the scalp lead to a temporary refractoriness of the epidermis to the fungus without conveying a similar refractoriness to the hair itself.

TREATMENT

Cases with little erythema and edema receive a fungicidal application in a liquid or in an ointment base. The list of remedies is long. The panacea of external applications employed by laymen is revealing. Storkan[4] compiled the following items: juice of green walnut, soot and mustard compresses, vinegar and copper pumices, tobacco juice poultices, vaseline and lemon juice, gun powder and vinegar, barnyard soil and creosote. The doctor in charge of the treatment of tinea capitis must have a good understanding of his patients and their parents and have a thorough knowledge of the available medications and procedures; it is not only what is used but also how it is used. Simple metals like mercury, synthetics such as fatty acids or alkaloids like podophyllin act as fungistatics, fungicidals. In addition, these applications are often instrumental in bringing on an inflammatory reaction[5] which is so beneficial for tinea capitis.

Severe inflammatory cases do well with soothing local application of boric acid or lead acetate solution. The antibiotics are excellently suited to abate the hyperactive phase; they effectively reduce the cellulitis, the lymphadenitis. The participating bacterial elements can thus be eliminated without hampering a favorable outcome, once the body's reaction to the fungus was set into motion. The aggravation of an already inflamed condition is not the prerequisite of a surer or prompter recovery; overtreatment causes unnecessary hardships. Disseminated microsporids or trichophytids may follow the focal infection spontaneously or, especially, if intensive local remedies were applied to the acute tinea capitis.

The lack of host reaction calls for active treatment while an active process calls for caution. The intermediary cases are judged on their own merits taking the extent of swelling, redness and discharge into consideration; the treatment is gauged accordingly.

Most of the approved fungus remedies, if used in the proper manner, will help to cure the disease. However, there are the chronic resistant cases that try the physician's faith in his therapeutic approach. It is essential that the medication be applied daily, that the patient be brought back at regular frequent intervals. The external application may have to be supplemented by the manual removal of the infected hair; a tedious job for the physician and a painful procedure for the patient. Yet, it is indispensable in the stubborn infections.

2. Pillemer, L., *et al.*: The Properdin System and Immunity. *Science,* 120:279 (Aug. 20, 1954).

3. Kligman, A. M.: (I) Infection with Microsporum Audouini. Journal of Investigative Dermatology, 18:231 (Mar., 1952); (II) Tinea Capitis due to Microsporum Audouini and Microsporum Canis. Archives of Dermatology, 71:313 (Mar., 1955).

4. Storkan, M. A.: Psychologic Factors in the Management of Tinea Capitis. Journal of the Am. Med. Women's Association, 9:356 (Nov., 1954).

5. Scully, J. P., Livingood, C. S. and Pillsbury, D. M.: Inflammatory Reaction as Index of Curability. Journal of Investigative Dermatology, 10:111 (Mar., 1948).

No vast amount of infected hair should act as a deterrent. With this added procedure, success can be achieved even in the apparently hopeless cases.

Some scalp infections do not yield to the outlined treatment. If we gain no clinical encouragement in the form of a shrinking patch, an activation of erythema and edema or a flare-up in a pre-existing low grade inflammation after 10 to 12 weeks of intensive management, the epilation of the scalp hair with superficial radiation must be contemplated. While radiation treatment is unwarranted unless the patient has had an ample and unsuccessful trial of local applications and manual epilation, harm can be wrought by an injudiciously prolonged treatment. It is a serious loss for a child to be kept out of school; it is frustrating and emotionally unwise for another child to be stigmatized by the sanitary cap; it is a physical hardship for the parents to use medications and shampoos and to take the child for treatments; there are the everlasting fears that the bald patch will remain and that other siblings will acquire the disease by contact. These are strong enough indications for taking the final measure to end the disease as early as clinically advisable and technically practicable.

X-ray epilation[6] of the scalp has been in use for many decades, and has proved its great value. It can be relied upon as a means to end the disease.[7] It is carried out through a five points method with the rest of the body closely shielded. It takes about 45 minutes. The irradiated hair begins to loosen on the 17th post-treatment day; it can be easily extracted by the 21st day. The scalp has to be cleaned of all hair during the ensuing eight days; using a one inch wide adhesive tape this goal is readily achieved. The stripping of the scalp of all the hair represents the second important phase of the radiation treatment. Should an infected hair remain, even if not viable, it may serve as a source of re-infection. Knowing, furthermore, that some hair breaks off during this operation, that other hair may be in a stage of growth below the skin surface, the patient has to report at weekly intervals and each emerging hair must be removed with a forceps. Only a close follow-up can insure a final cure. If there were any doubt about post-treatment cooperation on the patient's part or about facilities for medical follow-up the epilatory radiation should not be administered. Poor second stage therapy breeds treatment failure.

Reactions following x-ray treatment are rare. Such reactions include vomiting, drowsiness and restlessness. Occasionally, papular or nodular lesions develop in the scalp within a few days. An ephemeral pigmentation of the irradiated skin adjacent to the hairy scalp appears in some individuals after a lapse of 2 or 3 weeks. A fine crop of new hair begins to show after 2 months. The scalp hair regains its old density and color in 5 or 6 months.

All children infected with ringworm of the scalp must wear a protective cap when up and around. In this manner the spores are kept from spreading to other people, directly or through the mediation of some vector object. The same precaution is maintained after the epilating x-ray. The shampooing of the head throughout the treatment is recommended once or twice a week. This cleans the scalp and hair, by removing the dried up or excess medication. It has no curative effect.

The patient is "cured" when no infection can be detected on three successive examinations made at least 8 days apart. Only then can the precautions be lifted.

SUMMARY

1. Ringworm of the scalp is a constant threat to children; we must remain alert to this danger in our communities.

2. Trichophyton Tonsurans infection of the scalp has been added to the old, more familiar Microsporum infections.

3. Local application of medications, coupled with manual removal of the infected hair, if necessary, is instituted in patients with tinea

6. MacKee, G. M. and Cipollaro, A. C.: X-rays and Radium in the Treatment of Diseases of the Skin. Lea and Febiger, Philadelphia, 1947.

7. Cipollaro, A. C. and Brodey, A.: Control of Tinea Capitis. N. Y. State Journal of Medicine, 50:1931 (Aug. 15, 1950).

capitis when signs of a more severe inflammation are lacking. A fungicide, when capable of inducing a strong enough inflammatory response, increases the patient's chances for an early cure.

4. In acute cases soothing wet compresses and antibiotics are desirable to alleviate discomfort. Relief of signs and symptoms by the antibiotics does not have adverse effect on the course of tinea capitis.

5. Until the advent of a better method, x-ray epilation should not be withheld in resistant tinea capitis. It is a safe modality when applied with the proper technic. It is the treatment of choice with no relapse when the follow-up is carried out conscientiously. The success or failure of the radiation treatment hinges on the follow-up during the post-epilatory phase. This must be carried out with meticulous consistency.

220 Kearny Avenue

Ingrown Toenail

Roger Brearly writing in the *Lancet* (2:1038, 1958) describes a new way of treating ingrown toenails in young people which, he says, produces no deformity, no loss of function and no recurrence. Nerve block or general anesthesia is induced. A McDonald's blunt dissector is passed beneath the nail and the strip undermined is cut free and avulsed. A scalpel is introduced at the proximal end of the groove between the nailfold and nailbed, bisecting the angle between the two. It is pushed through, emerging from the lateral margin of the toe. The point of emergence should be well down toward the plantar surface, so that the points of entrance and exit are at least a half-inch apart.

Advance the knife distally, cutting a flap consisting of the nailfold and a substantial strip from the side of the toe. The knife then is turned, the flap tapered off and amputated at its base, beveling off the bare area proximally. The toe is wrapped lightly in a soft paraffin bandage, which is left for two weeks unless there are signs of sepsis.

Brearly also reviews the following technics:

1. Cutting the nail square, packing cotton wool beneath the corners and wearing wide shoes.

2. Thinning the center of the nail by scraping.

3. Cutting away a V at the center of the free edge of the nail.

4. Avulsion of the nail with or without curetting away granulations.

5. Filleting the nailbed off the dorsum of the phalanx.

6. The same, with skin-grafting of the raw area.

7. Filleting off the proximal portion of the nailbed, and closure by dorsal skin flap.

8. Watson-Cheyne's operation.

9. Willett's operation.

10. Amputation of half the terminal phalanx, including the nailbed, and primary closure by plantar flap.

11. Total amputation of the terminal phalanx.

When ulceration, suppuration and granulation are absent, 1, 2 and 3 usually succeed, especially in lesions of the adult type. When adult type lesions do not yield, amputation of half the phalanx with ablation of the nailbed is satisfactory. For infected juvenile type lesions, 1, 2 and 3 are unsatisfactory; 4 is followed by recurrence; 5, 6 and 7 are often marred by painful recurrent spicules of nail; 8 has both faults; 10 and 11 are mutilating.

S. J. Fanburg, M.D.

Newark

Ancillary Therapy of Dermatoses with Perphenazine*

While perphenazine was not found effective in relieving itching or other skin lesions, it was helpful in reducing the emotional component of certain dermatoses.

Although their exact role is not clearly understood, there is no doubt that emotional factors play a role in skin disease. Reduction of the emotional component usually diminishes the frequency [1] and intensity [2] of skin eruptions.[3] For this reason many dermatologists prescribe tranquilizers in addition to standard therapy.

Most of today's tranquilizers are phenothiazine derivatives. Chlorpromazine was the first of these agents. Later, modifications of the phenothiazine radical made possible elimination of certain disadvantages associated with chlorpromazine and extended the range of usefulness of these agents.

One of the newest phenothiazines, perphenazine* was selected for this study because it was experimentally shown [4] to have greater potency [5] and less toxicity [6] than others in its class. Trilafon® does not change respiratory or cardiac function and does not alter the blood chemistry; the only significant clinical side effect is reversible parkinsonian tremor.[7,8]

Ayd [9] confirmed the rapid absorption, increased potency, and relative freedom from toxicity and side effects of perphenazine.* Ernst and Snyder [10] reported good or excellent results in relieving anxiety among 42 of 56 ambulatory patients; Marangoni,[11] using high dosages among hospitalized patients, obtained markedly favorable results in 51 of 60 with emotional problems. Preisig and Landman [12] treated 103 office patients whose tension and anxiety complicated somatic illnesses, obtaining favorable results in 74. Parish [13] used perphenazine* in 129 patients of whom 36 had dermatoses of allergic origin; tension and anxiety were reduced in all and some patients also experienced

*The brand of perphenazine used in this study, tradenamed Trilafon® was supplied for our use by G. Kenneth Hawkins, M.D., Division of Clinical Research, Schering Corporation, Bloomfield, N.J.

1. Eisenberg, B. C.: Tranquilizing Drugs in Allergy. J.A.M.A., 163:934 (March 16) 1957.

2. LeVan, P. and Wright, E. T.: Tranquilizers in Diseases of the Skin. California Med., 85:87 (August) 1956.

3. Reiss, F.: Psoriasis and Stress. *Dermatologica*, 113:71 (August) 1956.

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7. Cahn, C. H. and Lehmann, H. E.: Perphenazine in Psychotic Conditions. Canad. Psychiat. A. J., 2:104 (April) 1957.

8. O'Reilly, P. O., *et al.*: Perphenazine Treatment of Psychoses. Canad. M. A. J., 77:952 (May 15) 1957.

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11. Marangoni, Bruno A.: Trilafon® in Anxiety and Tension. Am. Pract. & Digest. Treat., 8:1959 (December) 1957.

12. Preisig, R. and Landman, M. E.: Trilafon® in Anxiety States. Am. Pract. & Digest. Treat., in press.

13. Parish, Fred A.: Relief of Anxiety in Asthmatic Patients with Perphenazine. M. Times, in press.

diminution of physical symptomatology. These authors commented on the mildness and infrequency of side effects.

Recently Shanon [14] conducted a well-controlled dermatologic and psychiatric study among 308 patients with various dermatoses to evaluate the effect of Trilafon® at various dosage levels on pruritus with emotional symptoms in 144 patients. At the optimal dose of 16 milligrams daily, emotional factors were reduced considerably and many of the pruritic patients reported some relief of that symptom. Yontef [15] used Trilafon® in 89 dermatologic patients and found that anxiety was relieved to some extent in all; 33 patients also evidenced improvement of the skin lesions.

METHOD

PERPHENAZINE* was administered to 35 male and 65 female patients, ranging in age from 2 to 76 years, who suffered from various dermatoses and appeared to be especially tense or anxious. Pruritus was a presenting symptom in 77 of the 100 patients.

The dosage range was 2 to 24 milligrams of Trilafon® daily in divided doses, with most patients receiving 8, 12, or 16 milligrams daily. Therapy was continued for 2 to 8 weeks. Since the perphenazine* was used primarily as an adjunct to control the emotional component, all but 15 patients received specific therapy such as topical steroids, ultraviolet radiation, or antifungoidals in addition to the tranquilizer.

RESULTS

THE symptoms for which perphenazine* seemed indicated were subjective and therefore the effect of the drug could not be measured objectively. Our estimation of results is based on clinical impression and reports by the patients.

Relief of tension and anxiety was uniformly good in all patients treated. Many who improved during administration of Trilafon® had previously failed to benefit from specific therapy alone.

The secondary results of therapy with perphenazine* are summarized in the table. In the 77 patients with pruritus, Trilafon® produced marked relief in 12, slight relief in 7, and was ineffective in the other 58. Although the drug does not appear to have marked or reliable antipruritic activity, it may afford some relief of the symptom through the generalized tranquilizing effect.

We were able to evaluate any specific effect of perphenazine* on the dermatologic lesions in the 15 patients who received no other therapy. Three patients (one each with atopic dermatitis, neurodermatitis, and pruritus ani) evidenced marked dermatologic improvement.

Side effects occurred in only five patients and were insignificant except for one instance of parkinsonian tremors of the hand and head. Two patients reported drowsiness, one expe-

14. Shanon, Jay: Trilafon® in Dermatology. A.M.A. Arch. Dermat., 77:119 (January) 1958.

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Patients	Indication	Effect on Pruritus			Effect on Lesions		
		None	Some	Symptom Absent	None	Some	Other Therapy Used
7	Acne	1	0	16	1	0	6
14	Alopecia	0	1	13	2	0	12
6	Atopic dermatitis	2	4	0	0	1	5
18	Contact dermatitis	16	2	0	0	0	18
2	Dermatophytoses	1	1	0	0	0	2
13	Eczema	11	2	0	1	0	12
1	Granuloma annulare	1	0	0	1	0	0
6	Lichen planus	5	1	0	1	0	5
9	Neurodermatitis	5	4	0	1	1	7
2	Neurotic excoriation	2	0	0	0	0	2
1	Pityriasis rosea	1	0	0	0	1	0
4	Pruritus ani	1	3	0	0	0	3
8	Psoriasis	5	0	3	1	0	7
1	Scleroderma	0	0	1	0	0	1
4	Seborrheica	4	0	0	2	0	2
4	Urticaria	4	0	0	1	0	3
100							

rienced insomnia, and one had diarrhea. These reactions disappeared when medication was discontinued.

CONCLUSION

PERPHENAZINE* appears to be a useful and important adjunct in the treatment of various skin diseases. The patient feels better when tension and anxiety are suppressed and he is thus more cooperative in the total medical management. However, perphenazine* does not replace specific therapy in dermatoses since it is only moderately effective against pruritus and without much effect against skin lesions.

SUMMARY

TRILAFON® (perphenazine) was administered as ancillary therapy to 100 patients of all ages with dermatoses and associated tension and anxiety. The drug was effective in relieving the emotional component in all patients but was less effective against pruritus and skin lesions. It should be used in addition to, rather than instead of, standard forms of specific therapy. Side effects are few, mild, and easily reversible.

31 Lincoln Park

Magnesium Metabolism

Writing in the January 1959, *Current Medical Digest,* John C. Krantz reviews the little-discussed problem of magnesium metabolism.

The normal adult human body contains about 20 Grams of magnesium; 98 per cent of this is found in the soft tissues and bones. The serum magnesium level reported from various laboratories varies from 1.21 to 2.49 mEq/L. which is approximately 2 milligrams per cent. The daily magnesium requirement is about 5 mg./Kg. of body weight. In the diet this is provided by leafy, green vegetables, milk and meat.

Excessive concentrations of magnesium in the serum exert a depressive action on the central nervous system. For this purpose magnesium sulfate has been used intramuscularly to combat convulsive seizures. To achieve a high serum magnesium level, the magnesium salt must be administered parenterally.

Rats, deprived of magnesium, manifested hyper-irritability followed by convulsions and death. Fink *et al.* demonstrated low magnesium levels in patients with delirium tremens. *The symptoms responded dramatically to parenteral magnesium sulfate therapy.*

The magnesium ion is an important biochemical factor in the intermediate metabolism of glucose. This ion plays an important role in depression (high magnesium levels) and stimulation (low magnesium levels) of the central nervous system.

Allergy Control Tips

If a woman sneezes every time she uses perfume, she may be sentitive to orris root. Smaller concentrations of the root in her cosmetics may be precipitating a constant nasal irritation, reports Faye L. Landrum, R. N. Air conditioning seldom is recommended for the patient who is allergic to house dust; its currents also circulate the dust in the room and may aggravate the symptoms.—*The American Journal of Nursing,* May, 1958.

Woodrow S. Monica, D.M.D.

Orange

Headache Caused by Contractions of Masticatory Muscles

An unusual but readily remediable cause of headache is portrayed in this brief paper. It also offers a chance to learn a new word: bruxism. What is it? Read Dr. Monica's paper and find out

Sustained contractions of the temporal muscles can cause disagreeable head pains. This has been demonstrated in both hypertensive and normotensive patients by Tunis and Wolff.[1] Medical practitioners should also realize that in abnormal mouth habits, like grinding, gritting and clenching, the masticatory muscles are stimulated beyond their physiologic function. These forceful and prolonged contractions may cause bilateral headaches.

The following are selected from 7 case reports of patients successfully treated by dental rehabilitation. These illustrate bilateral headaches caused by abnormal grinding habits. In all seven instances, one or more experienced physicians examined the patients and found no organic disease. The physicians had treated the patients for headaches for one to ten years and could induce only temporary relief.

CASE ONE

A 39-year old, tense housewife complained of pain over the temporomandibular areas and of recurrent headaches in the suboccipital area. The headaches started ten years ago after the insertion of a gold crown on a lower anterior tooth. The gold crown always felt "thick" to her. She had a full complement of teeth, but the occlusal surfaces were abnormally worn away. She ground her teeth at night and often clenched them during the day. In addition, she had a "chipmunk" appearance at the angles of the mandible.

Her occlusion was adjusted at weekly intervals for three treatments. About two weeks after the last treatment, she was symptomless. One year later she was asymptomatic and the "chipmunk" look had disappeared.

CASE TWO

A 38-year old housewife, complained of daily headaches in the temporal area. The headaches started about five years ago.

She had 32 sound, natural teeth that were considerably worn from clenching and night grinding. Her mouth was clean, but she had a malocclusion.

Her occlusion was equilibrated on three occasions. Two weeks after the last adjustment, she was free of headaches. She returned at regular intervals for three years and was asymptomatic.

COMMENT

During the normal chewing cycle the teeth make contact only on swallowing.[2] The bolus of food lodges between the teeth and prevents an enamel-to-enamel contact. However, the teeth do touch in the later stages of

1. Tunis, M. and Wolff, H. G.: Archives of Neurology, and Psychiatry, 71:425 (April) 1954.
2. Jankelson, *et al.*: Journal of the American Dental Association, 4:375 (April) 1953.

c. *Spinal brace*—A spinal brace for lifting weight over the affected area may be supplied at a maximum allowance of $40.

d. *Cervical collar*—A cervical collar may be supplied at a maximum allowance of $16.

e. *Cervical brace*—A cervical brace may be supplied at a maximum allowance of $40.

f. *Oral prostheses*—Members of the New Jersey State Dental Society have agreed to provide at net cost certain oral prostheses for approved cancer patients. Members of the Society will not charge professional fees.

3. Of necessity, limitations and strict reguations must be made in supplying all types of prosthetic appliances. Such appliances should be supplied only when the prognosis is excellent. County chapter workers are advised to familiarize themselves with these regulations before entering into any agreements about the rehabilitation program.

4. Rehabilitation under this program is applicable only in those cases *not* eligible for aid under the provisions of the New Jersey Rehabilitation Commission.

Footprints in Identification of the Newborn

The February issue of the N. J. Hospital Association *Reporter* discusses inquiries about the practices of New Jersey hospitals in taking footprints of newborns for identification purposes. Assemblyman Miller of Union County introduced a bill on January 19 (A-251) which would require such a print on the reverse side of the official birth certificate form of all infants born in hospitals. Hospitals would install such procedures if they were in the public interest. But how accurate is a footprint for identification purposes? What is the risk of infection from the process?

A nation-wide survey was recently made of police identification experts, including those in states which require footprinting of newborns. Less than 5 per cent of the prints can be read, *i.e.*, 95 per cent of the prints are of no value whatsoever for identification purposes.

Aside from the problem of the identification of a newborn after he leaves the hospital, hospitals would do well to examine not only the adequacy of their identification methods of all patients, but each procedure in the process by which the identification is accomplished to be sure that it is foolproof and safe.

Cigaret Filtration and Carcinogenesis

A study* to determine possible differences in biological effects between tars of filtered and unfiltered cigarettes revealed no statistically significant variants in carcinogenic activity in experimental mice. The authors are careful to point out that these findings do not rule out filtration as a principle, but merely indicate that at the present time filtered cigarettes are not selectively removing the carcinogenic components of tobacco smoke. The authors comment that it is possible to produce filter tips that will allow the cigarette a satisfactory pressure drop and satisfactory flavor, at the same time removing about 40 per cent of the tar. In a regular-size cigarette, this could reduce tar exposure of the smoker from the present yield of 30 milligrams of tar in its smoke to 18 milligrams. Assuming the same number of cigarettes were smoked, this would materially reduce the cancer risk.

On a Gram-to-Gram basis, the carcinogenic activity of the tar from the smoke of filtered cigarettes was similar to that of the plain-tip cigarettes. King-sized cigarettes yield more tar than the old standard-size cigarettes. Some of the larger cigarettes with filters actually expose the smoker to more tar than do the old small-sized unfiltered cigarettes.

*Wynder, E. L. and Mann, Jona.: American Practitioner, July 1958.

Harold S. Feldman, M.D

Livingston

Results with a New Agent for Appetite Control*

(Levo-1-phenyl-2-aminopropane alginate)

Obesity is America's most prevalent chronic disease. Many methods have been developed to fight the battle of the bulge. Here is one which uses an alginate drug—and also a low calorie diet.

Many patients, even with the strongest motivation, require aid in appetite control. Proteins and bulk-producing foods contribute to the sense of satiety, but they cannot wholly eliminate excessive desire for food. Most successful in this respect have been the anorexigenic sympathomimetic amines—d-amphetamine and desoxyephedrine. In a recent survey,[1] however, it was found that there is widespread dissatisfaction among physicians with the anorectic compounds now available. Major complaints are: central nervous system overstimulation, cardio-vascular side effects, habituation, the development of tolerance and high cost. Their effectiveness in weight reducing regimens is limited by the fact they usually cannot be taken after 4 p.m. without causing insomnia. Thus night-time hunger remains a serious problem. Furthermore, over prolonged periods, the amphetamines may cause mood depression.

Recently, an appetite suppressant which appears to have several advantages over the usual anoretics has become available. This drug is 1-phenyl-2-aminopropane alginate.†

According to toxicity studies in mice[2] it is five times safer than d-amphetamine sulfate. In extensive clinical trials, patients were found to lose an average of 2 to 2½ pounds per week. The medication was given as late as 8:00 p.m. without causing insomnia, and no constipating effects were reported.[3] Also, its cost is low—frequently, an important consideration.

Preliminary biochemical studies by us indicate that the 1-phenyl-2-aminopropane alginate's mode of action is probably related to the large size of the alginic acid molecule which slows down the dissociation and smooths out the absorption of the phenylamine.

Gadek, *et al.*[2] have reported the results of a placebo study as follows: "Average weekly weight loss amounted to two pounds per week on 1-phenyl-2-aminopropane alginate, as compared with an average of one-half pound per week during the period the placebos were administered."

*This work is from the New York Medical College, Metropolitan Medical Center, New York City, and from the Department of Medicine and Nutrition Clinic.

†Available as Levonor®, manufactured by Nordson Pharmaceutical Laboratories, Inc., Irvington, New Jersey.

1. Gosselin, R. A.: Special Study, Treatment of Obesity. *To be published.*

2. Gadek, R., Feldman, H. S. and Lucariello, R. J.: Management of Overweight. Scientific Program at AMA Clinical Meeting, Philadelphia. December 3, 1957.

3. Development of a New Anorexigenic Drug. Scientific exhibit, Michigan State Medical Meeting, September 24-26, 1957.

Our own preliminary observations and the reports of others[4] prompted us to test 1-phenyl-2-aminopropane alginate in a number of overweight patients. At present the series, selected at random, includes 45 patients, 27 of whom are females. Age range is from 15 to 61 years. So far, the patients have received the drug for periods ranging from 2 to 14½ weeks. At the beginning the dosage was usually one tablet (5 milligrams) twice a day, mid-morning and mid-afternoon. After some experience it was found that most of the patients in the study required three tablets daily, taken before each meal or in the mid-morning, mid-afternoon and early evening. Dosage must be individualized. All patients are on low calorie (1030 or 1200) diets.

CLINICAL RESULTS

On this program, weight loss has averaged 2.4 pounds per week. Patients have been pleased with the results and with their ability to tolerate the medication. None have complained of insomnia. This is particularly striking in view of the fact that several of the patients have taken the drug as late as 8 or 9 p.m. There have been no complaints of headache or constipation. Patients who had been taking preparations containing d-amphetamine miss the "lift" associated with this when transferred to 1-phenyl-2-aminopropane alginate,† since the latter has no apparent effect on mood.

4. Gadek, R., Feldman, H. S. and Lucariello, R. J.: A Study of 1-phenyl-2-aminopropane alginate. Journal of the American Medical Ass'n., 167:433 (May 24) 1958.

In several such cases, not included in the above series, the use of a d-amphetamine preparation in the morning and of Levonor® during the evening proved satisfactory.

Results are summarized in the charts.

The following five case histories indicate the types of patients treated, and the typical results:

CASE ONE

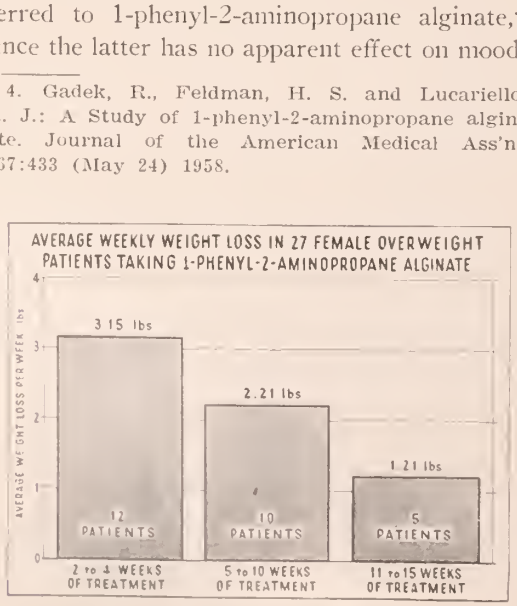
A 36-year old housewife found it difficult to lose 10 to 15 pounds over a period of six months prior to alginate† therapy. At the onset of treatment, her weight was 140 pounds. She was placed on a 1030 calorie per day diet and given one Levonor® tablet one-half hour before each meal. In 3 months, she lost 9½ pounds on this program. She was cooperative and stated that previous "drugs" supposed to depress her appetite had, on many occasions, overstimulated her, and this had led to unwillingness to cooperate with the regimen as a whole. No adverse effects were observed in this patient during her course of therapy.

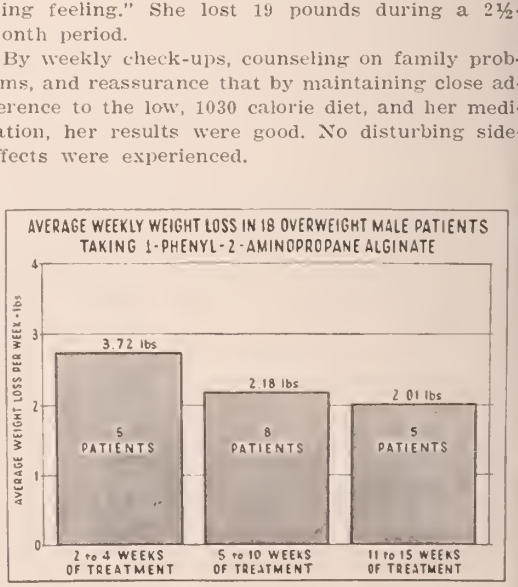
CASE TWO

A 34-year old housewife has been self-dieting on and off for a period of three years. She would lose 1 to 2 pounds on a restricted regimen and then gain back 5 to 8 pounds when emotionally upset by her children and husband.

This patient initially weighed 159 pounds. She was given the alginate† (1 tablet one-half hour before each meal) and was instructed to take one tablet between 7 and 8 p.m. if she had "that nibbling feeling." She lost 19 pounds during a 2½-month period.

By weekly check-ups, counseling on family problems, and reassurance that by maintaining close adherence to the low, 1030 calorie diet, and her medication, her results were good. No disturbing side-effects were experienced.





CASE THREE

A 40-year old housewife had dieted on many occasions. She had been on various routines, including low-calorie diets, with dextro-amphetamine and other appetite curbing medications. Initially, her weight was 188 pounds. On a 2-month period of Levonor® (one tablet one-half hour before meals) plus an occasional tablet between 8 and 9 p.m. to control "night-time snacks," she lost 22 pounds, and had no significant side effects. There was, as there often is, an emotional component here. While on the medication and losing weight, her behavior was within normal limits. During emotional upsets, her weight gain was evident and she was instructed to adhere as closely as possible to her routine. Advice was given concerning her family problems.

CASE FOUR

A 61-year old chemical maintenance worker began his dietary-control regimen with a weight of 182 pounds. He was placed on a 1030 low-calorie diet plus one Levonor® tablet one-half hour before each meal and hexavitamins daily.

After three months on the regimen, he lost 29 pounds, without complications. He had a surgical repair of bilateral inguinal hernia during this period.

CASE FIVE

A 43-year old civil engineer has always been "on the obese side." Initially his weight was 223 pounds. During a three-month course of Levonor® therapy (1 tablet at 11 a.m., 4 p.m. and 8 p.m.) plus low caloric intake (1030 calories per day), he lost 30 pounds. No side-effects—such as insomnia, irritability, or "nervous system" stimulation—were observed. He was troubled on occasion with eating between meals and at night. At conclusion of this therapy, he stated the medication helped him control his bad eating habits while learning to adopt better ones.

DOUBLE BLIND STUDY

Methods and Materials: Identically appearing tablets were prepared and assigned coded numbers "A" and "B". The tablets were packaged in bottles of 100 each. The bottles marked "A" contained the active drug, while the "B" bottles were the placebos. The investigator did not know the key to the code numbers.

The familiar Latin-square technic was modified in such a way as to divide the twenty-four patients into two groups. Alternate patients, selected at random, received a two-week supply of either "A" or "B" tablets. The distribution of weights in the two groups was in the same range, approximately 15 to 20 per cent over patient's ideal weight. The patients were directed to take one tablet one-half hour before each meal. All patients were placed on a 1030 calorie diet per day. There were nine females and three males in each group. All subjects were private patients.

The plan was to have each patient return every two weeks to be weighed, have blood pressure and pulse rate checked, and finally to be questioned by the investigator. On the second visit, a new supply of tablets with a different code number was to be given each patient. On the third visit, each patient was to be given a supply of the tablets with the original code number. In other words, each patient was to be his own control.

Unfortunately, it soon became apparent that many of the patients who had been given the "B" tablets would not cooperate. We then learned that the "B" tablets were the placebos. As a result, our observations were made over a much shorter period of time than planned.

Results: Out of the twelve patients on the placebos (code number "B"), eleven would not cooperate. As a result, we were not able to carry out the study beyond the first stage.

Eight patients on the placebo and a 1030 calorie diet averaged a weight loss of 14½ ounces per week for the two-week period. Four patients gained an average of 8 ounces per week.

The twelve patients on the active drug plus a 1030 calorie diet showed an average weight loss of 2.5 pounds per week for the two-week period.

Five of the eleven patients who would not cooperate with the placebo program did agree to continue when it was explained that the fault might be the dosage. They were then instructed to take two tablets (code number "B") one-half hour before each meal. At the end of one week, three of the patients called to report "the drug was not effective" and asked to be placed on some other medication. The other two patients cooperated during the course of the two-week period, but showed a

weight loss of one-half pound in one case and a 2¼ pound gain in the other.

Due to lack of patient cooperation, the double-blind part of the program was not carried through to completion, but we were satisfied from what we observed that 1-phenyl-2-aminopropane alginate† is an effective appetite suppressant.

COMMENT

It is generally thought that a person is overweight if his weight at any age is 10 to 15 per cent over the ideal at the age of 30 to 35. This is determined by reference to standard weight tables compiled by insurance companies. It is my experience, however, that the individual's *weight history* provides a more satisfactory index than do insurance tables.

Following a normal rate of gain during childhood and adolescence, the average individual reaches his "ideal weight" and remains at that level with surprisingly small variations. The overweight person may have a similar pattern, with the difference that weight stabilization has taken place at a higher level. This higher weight, to which he clings so tenaciously, is apparently normal for *him*. It is that weight at which overall adaptation to environment is most satisfactorily made. In such cases, *when weight reduction is attempted, it is successful only at the expense of his physical and mental well-being*. When, as is usually the case, the weight returns to its previous level, balance is restored.

A gradual increase in the weight curve, however, does suggest the need for weight reduction. Sudden changes in weight—rapid losses as well as gains—signify serious underlying disturbances, and demand careful investigation.

To be properly evaluated, weight trends should be considered in the light of the health history of the patient. Rapid increases in weight are dangerous when associated with the appearance of illness or the aggravation of a pre-existing disorder. Recurrent obesity is obviously undesirable in the presence of diabetes, heart disease or hypertension. It should be recognized, however, that unless the cause of overeating can be removed or adjusted to, a program of rigid dietary restriction may not only result in the appearance of other disturbances, but also in the aggravation of the disease for which it was undertaken.

Therefore, when the pattern of the weight curve, either by itself, or in relation to the health history, suggests the desirability for weight reduction, attention should be directed toward determining the conditions favoring overeating.

SUMMARY

Results in a series of 45 overweight patients indicate that 1-phenyl-2-aminopropane alginate,† a new agent for appetite control, is a highly effective adjunct to the reducing regimen, and that its use is not accompanied by central nervous system overstimulation and other side-effects commonly associated with anorectic agents. On our program, weight loss averaged 2.4 pounds per week.

A double-blind study in 24 cases established the new drug's effectiveness under controlled conditions, and also underlines the difficulties in completing such observations in private patients. If psychic stimulation is desired in conjunction with weight reduction, 1-phenyl-2-aminopropane alginate,† is not indicated.

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The author wishes to thank Judith Nelson Feldman for her technical assistance.

W. Austin Tansey, M.D.

Short Hills

Richard Wagner, M.D.

Summit

Ventricular Standstill

Treatment with the Cardiac Pacemaker

In this hypertensive age, one of the desperate emergencies that may confront any physician is ventricular standstill. In this practical paper, Dr. Tansey and Dr. Wagner present a compact and ready-reference monograph of management.

The syncopal attacks associated with heart block and abnormalities of cardiac rhythm are unpredictable and often present desperate therapeutic problems. These syncopal episodes are due to cerebral ischemia and may be related to a very slow idioventricular rhythm, ventricular standstill, ventricular tachycardia, or ventricular fibrillation. In a large series of cases in which death could be documented as being due to ventricular standstill vs. ventricular fibrillation, the standstill was eight times more frequent.[1] If the patient can be tided over these episodes he may live for years. Blood flow must be restored within three minutes if cerebral function is to return unimpaired.

Certain drugs may arouse, accelerate, or maintain idioventricular pacemaker. These include epinephrine, isopropylarterenol (Isuprel®) and phenylephrine. Other drugs may be used to halt the rapid ventricular rhythm and to dampen the irritability of the ventricle, such as quinidine and procaine amide (Pronestyl®). Still others are used to improve or stabilize A-V conduction; these include atropine, methantheline (Banthine®), epinephrine, isopropylarterenol, corticotropin and glyceryl trinitrate. In persistent ventricular standstill epinephrine may be used as follows. Four cubic centimeters of a 1 to 1000 aqueous solution is added to 1000 cubic centimeters of 5 per cent dextrose solution, or to normal saline. This is given as an intravenous infusion at the rate of 1 to 4 cubic centimeters per minute. Another method of using epinephrine is the intracardial injection of 0.1 to 0.5 cubic centimeters of a 1 to 1000 solution.

Prinzmetal and Kennamer[2] have found corticotropin useful in certain cases of heart block. The rationale for the treatment was as follows. It was felt that the complete heart block might not be due to permanent and complete destruction of the AV nodes and bundle in certain instances, but rather to an inflammatory reaction at the edge of the infarct. Since corticotropin is an anti-inflammatory agent it might often serve to diminish the block. They present a case in which this was successful.

When ventricular asystole is related to hy-

1. Stephenson, H. E., Jr., Reid, L. C. and Hinton, J. W.: Some Common Denominators in Cardiac Arrest. Ann. Surg., 137:731 (1953).

2. Prinzmetal, M. and Kennamer, R.: Emergency Treatment of Cardiac Arrhythmias. J. A. M. A., 154:1049 (March 27) 1954.

perkalemia, the intravenous injection of hypertonic (30 to 40 per cent) glucose covered with regular insulin, may suffice to restore sinus rhythm, until a dialyzer or other means is available to correct the electrolyte imbalance.

Bellet[3] has reported the successful use of molar sodium lactate. In one series this was successful in seven out of ten cases. He advocates 40 to 80 cubic centimeters of molar sodium lactate, given rapidly by vein, for severe cases. For mild cases, 10 to 20 cubic centimeters are given. After this initial dose, give 60 to 150 drops per minute, intravenously.

NON-DRUG procedures include vigorously slapping the chest, inserting a needle into the myocardium, cardiac massage, and the external cardiac pacemaker. In two large series of cases[1,4] in which open massage was done, the salvage rates were 28 and 34 per cent.

The pacemaker* was first introduced by Zoll[5] in 1952. In 1955 Zoll and Linenthal[6] published a paper in which they reviewed a number of cases where the cardiac pacemaker was successfully used. These included 37 with Stokes-Adams disease. The machine was used from one to 41 times in each of these 37 patients, for a duration of ten minutes to one hundred and nine hours. In addition, three further patients with reflex vagal standstill were treated successfully. Two patients with digitalis-induced standstill and two patients with procaine amide standstill were successfully treated. There was a miscellaneous group of eight cases resulting from various diagnostic and surgical procedures in which five were successfully treated with the pacemaker.

Cases in which there were ventricular standstill or a very slow idioventricular rhythm responded almost routinely to the pacemaker.[7,11] On the other hand where there were paroxysms of ventricular tachycardia or ventricular fibrillation, electric stimulation was not successful; but after abrupt cessation of this rapid rate the pacemaker proved occasionally successful.

Douglas and Wagner[8] report a 72-year old man in whom it was necessary to use the artificial pacemaker continuously for seven days before spontaneous idioventricular rhythm appeared. They used atropine, ephedrine, epinephrine in oil, barium chloride, and isopropylarterenol. Corticotropin, 40 milligrams, was given intramuscularly on only two days, and was stopped because it did not seem to help. With the use of the pacemaker, supplemented with the above-listed drugs, the patient made a complete recovery, and was asymptomatic two months after this report was made.

Kaye and Schickler[9] report a 79-year old man in whom the pacemaker was used at intervals totalling 48 hours over a period of five weeks, with ultimate success. Adreno-corticotropic hormone (25 milligrams) was given intravenously on two successive days. Epinephrine, ephedrine and atropine were also used.

Friese[10] described a woman in whom the use of the cardiac pacemaker was required for long periods: sixty-one, ninety, and fourteen hours. She had hypertensive cardiovascular disease, with disorder of atrio-ventricular conduction pathway. Her cardiac automaticity was re-established with the simultaneous administration of drugs.

The cardiac pacemaker is a modification of existing physiologic stimulators. It produces monophasic rounded electrical impulses with

*Manufactured by the Electrodyne Co., Norwich, Mass.

3. Bellet, S.: Treatment of Stokes-Adams Seizures. Modern Concepts of Cardiovascular Disease, 24:6 (June) 1957.

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an average duration of two to three milli-seconds. It is attached to the patient by two outlet wires connected to two electrodes. These electrodes resemble the one used for the V leads of the electrocardiogram. They are placed approximately at position of V 2 and V 6. Electrode paste is used to make contact. To minimize burning, the electrodes are shifted periodically to other positions in the area around V 2 and V 6. Chest pain resulting from the burn of these electrodes may be partly controlled by the use of meperidine (Demerol®).

The purpose of this report is to present a case of complete AV block in which the pacemaker sustained the heart rhythm until other measures were successful in restoring the conduction pathway. Hydrocortisone was used as an anti-inflammatory agent. Isopropylarterenol and aminophylline were used in effort to arouse and accelerate the AV conduction pathway. Meperidine allayed the pain; and chlorpromazine was used for its tranquilizing effect.

A 72-year old man was admitted to Overlook Hospital, Summit, N. J., because of repeated episodes of syncope culminating in stupor on the day of admission. He had not been under medical care for these episodes, which had begun several days before admission.

On admission he was in a critical condition. Apical pulse was only 30 beats per minute. Blood pressure was 80/30. He was placed in an oxygen tent. Electrocardiogram disclosed a complete block, with an idioventricular rhythm of 28 per minute.

During the first 18 hours after admission his apical pulse ranged from 19 to 25. By the next day, apical pulse was 14 per minute, feeble and irregular. His skin was cold, clammy, cyanotic. Blood pressure was 94/0. Epinephrine, nikethamide (Coramine®) and atropine had been used without avail.

At 1:15 p.m. the cardiac pacemaker was started. Response of patient's heart was at first intermittent. After the first 45 minutes, his pulse was 60 per minute, in response to pacemaker, which had been set at this rate. At 2:15 p.m., he began to react, his pulse at 60 per minute; blood pressure 156/90. At 8:10 p.m. (since he had not voided in twenty-four hours) he was catheterized, and 20 cubic centimeters of urine obtained. Figure 1 reveals the status of the ventricles during the first eight hours of the use of the pacemaker.

During this time, oxygen was administered by nasal catheter at 5 liters per minute. He was digitalized by a semi-rapid method. Digitoxin® was used for only a 24-hour period.

Other drugs used during this first twenty-four hour period on the pacemaker were atropine, aminophylline, isopropylarterenol, and hydrocortisone. Fluids and electrolytes were given parenterally, and were maintained in balance with frequent laboratory analyses.

After the patient had responded sufficiently to permit adequate evaluation of his heart sounds, the following was noted. Heart sounds were regular and of fair volume. A grade 2 (on the basis of grade 6) rough harsh late systolic murmur was heard over the entire precordium, more particularly medial to apex. This murmur terminated before the second sound. This murmur was unchanged throughout convalescence, including the most recent evaluation two months after admission. There never was a thrill, or a diastolic murmur, or a third heart sound.

The amplification dial on the pacemaker was set at 50. If it was lowered to 45, the patient's pulse became feeble and intermittent, and the patient relapsed into his former shock-like state. Upon returning the dial to 50, a few seconds would elapse; then the patient would become tonic all over, his face would flush, and, after several more seconds, he would respond.

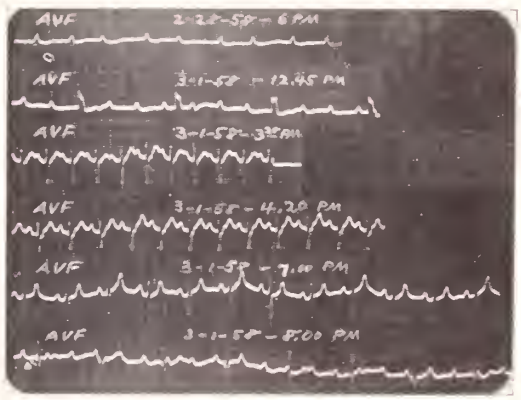


Figure 1.

At 12:30 p.m. on the second day, the pacemaker was shut off, but had to be resumed at 1:50 p.m. because his pulse had gradually fallen to 34 and his condition was deteriorating. Upon resumption of pacemaker, the pulse promptly returned to 60, and blood pressure to 145/60.

At 6:45 p.m. (twenty-nine hours after it had been started) the pacemaker was shut off. Thereafter the pulse remained 40 to 70, except for one minute interval at 7 a.m. on the fourth day, when the pulse had fallen to 32. During this minute, pacemaker was resumed and the patient responded promptly. During the ensuing two days pulse varied from 110 to 130 per minute. Blood pressure averaged 140 to 160 systolic over 60 to 80 diastolic.

At 4:50 p.m. on the sixth day, the pacemaker had to be resumed because of convulsive seizures. This time it was used for an additional 18 hours, making an aggregate use of the pacemaker 46 hours during this six-day period. It was discontinued on the seventh day at 10:50 a.m. and was not required again.

During the next several days, the pulse ranged

from 102 to 140; blood pressure 170 to 220 over 68 to 90. The temperature spiked to 105 on the third day; 101 on the fifth day, and ranged from 97 to 100 from the fifth to the fourteenth day. He was afebrile after the fourteenth day.

He voided only 20 cubic centimeters in the first twenty-four hours; thence in successive twenty-four hour periods: 100, 300, 710, 650 and 1500 cubic centimeters. Specific gravity ranged from 1.004 to 1.014; albumin from a trace to 2 plus.

On the second day, white blood count was 22,300 with 80 per cent polymorphonuclear leukocytes; on the fifth day the white blood count was 14,000 with 88 per cent polymorphonuclear leukocytes. SGO-transaminase level on the second day was 144 units. Sedimentation rate on the second day was 23 millimeters in an hour (Westergren).

Blood urea nitrogen was 66.8 milligrams per cent on the third day. Its peak was 180 on the eighth day. Thence it gradually diminished to 21.8 on the twenty-sixth day.

Chest x-rays on the 14th and 21st days were entirely normal Follow-up chest x-ray two months later, was also normal in every detail.

Levarterenol was tried briefly during the first hour of use of the pacemaker. Isopropylarterenol was used in large doses from the second day on. Hydrocortisone was given daily from the second day on, in intramuscular doses of 40 to 120 milligrams a day. Other drugs used were aminophylline, meperidine, Varidase®, chlorpromazine, and Combiotic®.

Initially the QRS complex indicated right bundle-branch-block; see Figure 2 (ninth day). On the nineteenth day, the QRS duration diminished to 0.09, and yet the contour of the ventricular complex remained the same. There were no pathological Q waves, and no current of injury noted in the ST-T segments. The tall peaked P waves in II and III were suggestive of right atrial hypertrophy.

The underlying pathology was never ascertained. Possible diagnoses were: acute myocardial infarction—involving the septum; inter-atrial septal defect; pulmonary emboli; subacute bacterial endocarditis.

When last examined, eight months later, the patient was asymptomatic and his only medication was isopropylarterenol Linguets, 15 milligrams every three hours. If indicated at a later date, an attempt will be made to resolve the differential diagnoses.

Prolonged use of the pacemaker presents a number of problems. There is considerable distress caused by the rhythmic contractions of the pectoral muscles. This can be partly abated by meperidine. If the electrodes are not moved periodically, the skin will be burned. In our case, the patient sustained a local erythema of the electrode area, no ulceration.

†Also made by the Electrodyne Company of Norwich, Massachusetts.

In many clinics a cardiac monitoring device is used so that ventricular standstill or fibrillation may be detected instantly. This device† will provide a stimulus for initiating the pacemaker, so that the patient will not have to have someone in constant attendance.

In a case, in which ventricular standstill might be anticipated, such as in complete heart block, it would be well to have the pacemaker electrodes *in situ* at the start of the operation. The composite monitoring and pacemaker device would be most appropriate in this instance.

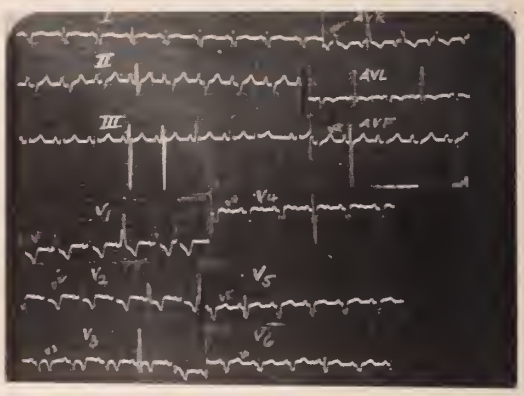


Figure 2.

A proposed program for management of ventricular standstill or fibrillation is detailed below. Of course every case must be individualized. The mention of a time limitation is merely to give a guide line so that each episode may be handled with utmost expediency. This is based on a supposed 3-minute limit of time available.

A. During the first sixty seconds.

1. Obtain cardiac pacemaker (ineffective in V.F.).
2. Mechanical stimulation of heart (while pacemaker is being applied).
   a. Slap precordium.
   b. Cardiac puncture.
   c. Massage through diaphragm if abdomen is open.

B. During second sixty seconds.

1. Cardiac pacemaker. This is ineffective in ventricular fibrillation or prolonged anoxia.

C. During or before third sixty second period, open and massage the heart.

1. For Ventricular Fibrillation.
   a. Electric countershock, 60 cycle a-c, 150 volts, 0.15 seconds.
   b. Procaine, 5 to 15 cubic centimeters of a 1 per cent solution into left atrial or left ventricular cavity.
   c. Potassium chloride, 10 milligrams into the left atrial or left ventricular cavity.
2. For Ventricular Standstill.
   a. Cardiac pacemaker directly on heart.
   b. Epinephrine 0.2 cubic centimeters of 1-to-1000, intra-cardially.
   c. Calcium gluconate 4 cubic centimeters of 10 per cent solution intra-cardially.

SUMMARY

1. Ventricular standstill or fibrillation occur in situations where they may be adequately managed in a statistically significant number of instances, such as in the operating room.

2. In two large series, the salvage rate with open massage method was 28 and 34 per cent.

3. The cardiac pacemaker, first introduced by Zoll[5] in 1952, is effective in ventricular standstill but not in fibrillation. In Zoll's series the pacemaker was successful to varying degree in all 37 cases of Stokes-Adams disease.

4. The various drugs and mechanical procedures available have been discussed. A program of management of ventricular standstill and fibrillation has been offered.

5. Another case, in which the cardiac pacemaker has been eminently successful, has been presented.

The authors acknowledge grateful appreciation to the following doctors who assisted in the case report. Drs. Henry A. Connolly, Simeon Yap, Antonio Jose, Paulino Chan, Dimitri Lalossis, Isidor Mcrdinger, Nancy T. Block and James Watt.

85 Woodland Road (W.A.T.)

The Surgery of Stroke

In 71 patients with stroke, seventeen of the lesions causing the cerebral insufficiency were extracranial. On angiographic examination 32 patients had lesions in the internal carotid, innominate, common carotid, vertebral, or subclavian arteries. There were 16 complete and 26 incomplete occlusions. Thrombo-endarterectomy was done in nine patients with occlusion of the internal carotid arteries or vertebral artery, and bypass grafts were employed in the others. Results emphasized the need for early angiographic examination and operation. Reasonably good distal circulation was restored in 15 of 16 patients with partial occlusion of the internal carotid artery; but in only one of 11 others with complete occlusion, and in one with partial occlusion of the vertebral artery, and not in another with a more extensive occlusion. Circulation was restored in all with occlusion of the great vessels originating on the aortic arch. In a five-year follow-up period, only one recurrence of an occlusion was seen.

—W. S. Fields and co-workers in November 1958, *Neurology.*

Poor Circulation Corrected

Legs with circulation so poor that patients faced loss through amputation have been restored to usefulness through transplanting grafts of blood vessels to the legs, three Ohio orthopedic surgeons report. In transplant surgery defective arteries are removed and replaced with a substitute artery permitting a more normal blood flow. Results have been equally good in diabetics and nondiabetics.—*American Academy of Orthopaedic Surgeons,* Feb. 4, 1958.

Milton E. Landman, M.D.

Bloomfield

New Therapy in Gastrointestinal Disease

Preliminary Report of 100 Patients

In this hectic age, the gastrointestinal tract has become the loudest sounding board of the emotions. Dr. Landman here reports good results in 73 per cent of his gastrointestinal patients by using two new synthetic drugs.

An emotional component complicates most cases of peptic ulcer and other gastrointestinal diseases characterized by hypermotility and hypersecretion.[1] Sedatives or, more recently, tranquilizers are often prescribed to supplement the effect of anticholinergics through reduction of the stress factor which precipitates or exacerbates symptoms.

Diphemanil methylsulfate (Prantal®) is a quaternary ammonium compound with marked anticholinergic action.[2] It is used clinically to reduce pain and enhance healing in ulcerative gastrointestinal disease.[3]

Perphenazine (Trilafon®) is a new amino derivative of chlorphenothiazine with the ability to reduce tension and anxiety.[4] It is used in gastrointestinal disorders for both its tranquilizing[5] and antiemetic[6] effect. We have used perphenazine in patients whose physical symptomatology is induced or complicated by an emotional component.[7]

The first study of diphemanil methylsulfate and perphenazine in combination was made by Winkelstein,[8] who reported good results in 95 patients with peptic ulcer and other types of ulcerative gastrointestinal disease.

Method*

I used diphemanil methylsulfate and perphenazine in 57 males and 43 females with gastrointestinal disease. Patients ranged in age between 23 and 71 years. Mean average age was 44. There were 20 patients with peptic ulcer, 5 with mucous colitis, 2 with chronic cholecystitis, one with diverticulitis, and one with hiatus hernia. The remaining 71 patients had "functional" disturbances manifested by dyspepsia, epigastric pain, gaseousness, and hypermotility of the stomach. The absence of organic disease was confirmed by radiographic examination.

Two dosage schedules were used: 53 patients received 8 milligrams of perphenazine and 400 milligrams of diphemanil methylsulfate daily, and 47 received 16 milligrams of perphenazine and 800 milligrams of diphem-

*Supplies of the drugs used in this study were provided by G. Kenneth Hawkins, M.D., Division of Clinical Research, Schering Corporation, Bloomfield, New Jersey.

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2. Margolin, S. *et al.*: Proceedings of the Society of Experimental Biology and Medicine, 78:576 (November 1951).

3. Rowe, C. R. *et al.*: Gastroenterology, 21:90 (May 1952).

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6. Weiss, S. *et al.*: American Journal of Gastroenterology, 29:173 (February 1958).

7. Preisig, R. and Landman, M. E.: American Practitioner and Digest of Treatment, 9:740 (May 1958).

8. Winkelstein, Asher: American Journal of Gastroenterology, 30:68 (July 1958).

anil methylsulfate daily. Usually four equal doses were given daily, before meals and at bedtime. Duration of therapy varied between one and 25 weeks, the mean average being 6 weeks; 63 patients were treated for a month or less.

Results were classified as "good" or "poor." Good results were recorded where there was distinct evidence of improvement. Results were considered poor if the degree of improvement was questionable.

RESULTS

OF THE 20 patients with proved chronic peptic ulcer, 13 had very satisfactory results with diphemanil methylsulfate and perphenazine. The only untoward event was a gastrointestinal hemorrhage in a patient who had received the drugs for one month. He had previously undergone subtotal gastrectomy and was being treated for marginal ulcer. Three of the 5 patients with mucous colitis responded well. One of the two who failed to respond had been refractory to all other therapies. One patient with chronic cholecystitis and cholelithiasis did remarkably well, having been carried for four months without symptoms until surgery became feasible. The other patient did not benefit. The patient with hiatus hernia was much improved. Marked constipation occurred in the patient with diverticulitis and medication was discontinued. The combination was satisfactory for 55 of the 71 patients with functional gastric distress. See the tabulation.

No serious side effects occurred. Eight patients reported drowsiness and three became constipated. Of these 11 patients, four had received 16 milligrams of perphenazine and 800 milligrams of diphemanil methylsulfate daily. The others received the lower dosage schedule.

SUMMARY

DIPHEMANIL methylsulfate, 400 or 800 milligrams daily, and perphenazine, 8 or 16 milligrams daily, were administered to 100 patients with gastrointestinal disease. Results were very good in 73. There were no serious side effects. Drowsiness occurred in 8 patients and constipation in 3. It was usually possible to continue therapy, occasionally at a reduced level, for as long as necessary.

CONCLUSION

THESE agents, used in combination, provide another useful adjunct in treating conditions of the gastrointestinal tract characterized by hypermotility and hypersecretion. The degree of effectiveness compares favorably with that of similar compounds. Side effects are minimal.

RESULTS OF THERAPY

400 mg. Prantal® + 8 mg. Trilafon®					800 mg. Prantal® + 16 mg. Trilafon®			
Patients	Good Results	Poor Results	% Good Results		Patients	Good Results	Poor Results	% Good Results
41	31	10	75	"Nervous stomach"	30	24	6	80
9	6	3	67	Peptic Ulcer	11	7	4	63
1	0	1	0	Mucous Colitis	4	3	1	75
1	0	1	0	Chronic Cholecystitis	1	1	0	100
1	0	1	0	Diverticulitis	0	0	0	0
0	0	0	0	Hiatus Hernia	1	1	0	100
—	—	—	—		—	—	—	—
53	37	16	70	Totals	47	36	11	76

1185 Broad Street

Special Article • • •

Your Role in Social Security Disability Determination

Every doctor may have to help a patient by furnishing disability reports. In this compact guide, the facts and needs are clearly spelled out. If you do not bind your Journals, clip and file these pages.

You are often asked to fill out medical reports in connection with claims under the disability provisions of the social security law. These provisions protect severely disabled people in three ways:

1. Benefits are provided for insured workers age 50 to 65 who are no longer able to work because of disability. Benefits may be paid to wives and dependent husbands who have reached retirement age, unmarried dependent children (including sons or daughters disabled in childhood), and wives, regardless of age, who have in their care children entitled to benefits.
2. Benefits may be paid to adult disabled sons and daughters of retired workers and of workers who have died. To be eligible for these benefits, the disabled son or daughter must have a disability which began before age 18 and has continued uninterruptedly.
3. Disabled workers, regardless of age, can "freeze" their social security records to protect their own and their families' future benefit rights.

To qualify under these disability provisions, a person must be unable to engage in any *substantial gainful activity* by reason of a *medically determinable* impairment which can be expected to result in death or to be of long-continued and indefinite duration. A disabled worker must, in addition, have social security credits for work in at least 5 out of the 10 years before he became disabled and must be fully insured. The social security credits needed depend on age. Five years of work under social security will be enough to meet the "fully insured" requirement through 1960. Anyone with 10 years of social security credits is fully insured for life.

Benefits are not payable for the first six months of disability. However, the law protects a person who delays filing his application for some time after he meets the requirements for payment (including the six-month waiting period), in that it permits back payments for 12 months.

Workers with long-standing disabilities have until June 30, 1961, to apply to have their social security records frozen as of the time they actually became disabled. In some cases this may be as far back as October 1941, the first date when the work requirements could have been met.

Under the social security law the benefits payable to a child ordinarily stop at age 18. Where a disabled child was entitled to benefits before 18, his benefits will be continued so long as he is disabled. Otherwise his benefits begin when the parent on whom he is dependent becomes entitled to disability benefits (age 50 to 65) or to old-age insurance benefits, or dies, regardless of the child's age at that time. The disabled child does not need a record of work under social security. The disabled child must, however, meet the same definition of disability as disabled workers. The mother of the person receiving this benefit may qualify for mother's benefits if she has the disabled son or daughter in her care.

All applicants are referred to their State vocational rehabilitation services. Payments to the disabled worker and his eligible dependents are suspended, if the disabled worker refuses, without good cause, to accept rehabilitation services. If the disabled worker accepts rehabilitation services and performs work pursuant to an approved rehabilitation program,

benefits may continue for as much as 12 months after he starts that work.

Applications under the social security disability provisions are taken by district offices. The social security district office helps him to fill out his application, and advises as to the documents he may need to support that application. The disabled person is responsible for furnishing, *at his own expense,* the evidence to show that he is "disabled" within the meaning of the law.

The social security district office gives him a medical report form on which this evidence can be supplied. He is asked to take or mail this form to his physician or to a clinic or hospital, where he has been treated. This form lists the kind of medical facts essential for the determination of "disability." However, the reporting doctor is not required to use it; if he prefers, he may make his report in the form of a narrative summary or he may submit photocopies of the pertinent medical records. The completed reports are to be returned by mail.

BY PROVIDING a full and objective clinical picture of his patient, the reporting doctor fulfills his responsibility to his patient, and expedites the decision. To be of maximum use for the evaluation of a patient's capacity for work, the report should include a history of the impairment, the symptomatology, clinical findings and diagnosis. The attending physician is asked only to provide objective medical data. He is not put in the position of having to decide the issue of "disability." The determination as to whether a patient is "disabled" must be made within the scope of the social security law; often it is based on evidence from more than one medical source. Also the determination must take into account factors which are not purely medical—factors such as education, training, and work experience.

In New Jersey, the district office relays the case to the State Rehabilitation Commission, which makes the determination. This is done through a "review team" in the office of the State Rehabilitation Commission. The team includes a physician as well as a vocational expert. The team has to determine whether the applicant is sufficiently disabled to prevent him from engaging in any substantial gainful activity within the foreseeable future.

It is sometimes necessary to write back to the physician because the medical report does not contain enough clinical facts. As a rule, the facts that the physician needs in making his diagnosis and in treating his patient are the same as those required to evaluate the severity of impairments in disability programs. However, certain medical facts are more significant in disability evaluation than to medical management. To evaluate the effect of the impairment on the individual's ability to work requires the kind of medical evidence that confirms the diagnosis and measures remaining functional capacities of mind and body. By furnishing complete and objective evidence, the reporting physician makes it unnecessary for the reviewing physician to "write back" for additional data.

Where the medical evidence initially submitted indicates a reasonable likelihood that the applicant is disabled, but more precise findings are needed to arrive at a sound decision, or to resolve conflicts, a consultative examination may be ordered to obtain additional information. Selection of consulting physicians and payment of fees are governed by State practices.

Some doctors feel that they should be reimbursed for preparing medical reports. It is within their prerogative to charge the patient a fee for that service. However, under the law, the Social Security Administration cannot pay that fee; that is the individual's responsibility.

Other doctors are perturbed when asked to complete medical reports for individuals whom they may not have seen for years. In these cases, however, the physician is not expected to describe the present condition, but only the medical condition as of the time he made his last examination.

EVALUATION OF DISABILITY

The central purpose of disability evaluation is to determine remaining mental and physical capacities: (1) What the claimant has left, and (2) What he can do with what he has left.

A realistic evaluation of disability must be based on clinical and laboratory tests of the individual's ability to meet the metabolic demands of activity, to reason, to perceive, and to perform basic activities such as sitting, standing, bending and walking. When incapacity results from severe impairment of one or more functions, it is essential to establish not only the fact that functional impairment exists, but also its extent.

A brief discussion of disability from heart disease may serve to illustrate the kind of

evidence needed to measure the patient's remaining functional capacity, after appropriate therapy. Most frequently, impairments of the circulatory system produce loss of bodily function by reduction of cardiac reserve, or interference with peripheral vascular circulation. As a result the circulatory apparatus cannot meet effectively the metabolic demands placed upon it. The diagnosis of the condition usually reflects whether the impairment is caused by valvular disease, myocardial damage or vascular pathology.

Cardiac size by x-ray or physical and electrocardiographic findings furnish objective proof of cardiac pathology. The amount of dyspnea or angina described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk is significant to evaluation of the degree of loss of function. Cardiac edema and response to therapy are also indicative of severity of cardiovascular impairments. The status of the pulse in the peripheral vessels may provide gross clinical evidence of impaired circulation of the extremities.

Impairments of the cardiovascular system may manifest themselves with dramatic suddenness, *e.g.,* myocardial infarction, obstructions of vessels in peripheral or central nervous system circulation, lungs, and other visceral organs. The initial clinical manifestations are severe and the prognosis dubious. With survival from the acute stage, and appropriate therapy, substantial improvement can be expected over a period of time. A realistic evaluation of remaining function should be made after the convalescent period. Hence, the clinical and laboratory findings after maximum improvement from treatment are particularly valuable in making a determination of remaining cardiac, brain or other function. (Note that a "waiting period," is prescribed by law, *i.e.,* the first monthly disability insurance benefit cannot be paid until the seventh month after the onset of the disability.) A description of the acute attack helps confirm the diagnosis and should, therefore, be included in the report.

Loss of function is evaluated on the basis of clinical and laboratory findings after maximum benefit from treatment. Clinical information concerning nature and response to treatment furnishes information on stability of functional capacity, *i.e.,* a history of periodic decompensated heart disease, in spite of treatment, would indicate a comparatively severe condition.

More complicated tests of vascular function may be required in certain cases, *e.g.,* arteriography. The reporting physician should not be concerned because he may not have equipment to perform these tests. A carefully performed exercise tolerance test (if not medically contraindicated) will almost always provide the clinical evidence needed to evaluate the degree of remaining function.

CONCLUSION

In developing evaluation guides for the use of State agencies and its own personnel, the Social Security Administration has had the continuing cooperation of a Medical Advisory Committee of recognized specialists associated with medical and allied professions in various fields outside Government, such as general practice, research, medical education, industry and labor.

The American Medical Association has taken steps to inform its members about the medical aspects of the disability program, especially the preparation of medical reports. On June 1, 1957, the *Journal of the American Medical Association* carried a comprehensive report on the administration and organization of the disability provisions. Regulations on the meaning of disability appeared in the September 28, 1957, issue.

Radiologic Hazards

In accordance with the recommendation of Reference Committee "E" at the 1959 Annual Meeting, approved by the House of Delegates, that the following supplemental report of the Special Committee on Cancer Control be approved and be made available to all practicing physicians in New Jersey, the Board of Trustees at its meeting on May 17, 1959, directed that the following report be published in THE JOURNAL.

In order to reduce the radiologic exposure to citizens of the State of New Jersey, the following recommendations are submitted by the Subcommittee on Radiologic Hazards of the Special Committee on Cancer Control:

I. INDUSTRIAL HAZARDS

A. *Radioisotopes*

Since radioactive isotopes have been controlled by the Atomic Energy Commission, no additional recommendations are required. It is felt that radioisotopes not controlled by the Atomic Energy Commission, such as radium and cyclotron-produced isotopes, should be handled under the same regulations as those that are affected by the Atomic Energy Commission, with the same precautions being observed.

B. *X-ray for Welding, Examination of Parts, Quality Control*

1. All personnel in the area of radiation should wear film badges and/or pocket dosimeters on that part of the body that will be maximally irradiated. A log should be kept of each worker's exposure.
2. Each piece of x-ray equipment should be monitored by a competent person at regular intervals and a log kept of the findings.
3. All personnel who work with radiation should be educated about the hazards therein.

II. MEDICAL HAZARDS

This committee feels that diagnostic x-ray technics have been of major importance in maintaining health and in increasing the life span in our society. They have been of great value in the detection of disease. It is not our purpose to dissuade physicians and patients from these necessary procedures but, rather, to make recommendations so that these procedures may be carried out with a minimum of radiologic hazard.

A. *Fluoroscopy*

(a) Equipment and Procedures

1. At the table top, the output of the machine should be 5 r/min. or less.
2. Each machine should have a minimum filtration of 2 mm. of Al., which gives a h.v.l. between 2 and 4.5 mm. of Al.
3. Each field should be centered such that the center ray goes through the center of the screen. The shutter system should be so adjusted that with a maximum field there is approximately an inch of unirradiated screen. It is recommended that a slotted, hanging, lead rubber apron be attached to the appropriate portion of the fluoroscopic screen.
4. Each machine should be monitored to check the output, the h.v.l. and the stray radiation when installed and when any change is made in the equipment.
5. All machines should have a limiting timer attached to them.
6. It is recommended that as small a field size as possible be used.

(b) Personnel

1. Adequate time should be allowed for dark adapting.
2. Aprons of adequate length and with a minimum thickness of .2 mm of lead should be mandatory.
3. All personnel who are repeatedly exposed to radiation should be monitored by film badges and/or pocket dosimeters and a permanent log kept.
4. Education for radiologic protection should be carried out periodically.

B. *Radiography*

(a) Equipment and Procedures

1. There should be a filter in the beam of not less than 1 mm. of Al.
2. Cones should have an aperture as small as possible to just cover the film used at the required distance.

3. X-rays should be taken utilizing a technic that minimizes exposure to all areas that are not being examined, with particular attention to minimizing gonadal exposure.
4. Whenever the gonads may be exposed in the course of examining an adjacent area, it is recommended that a lead shield or lead rubber apron be used for additional protection.

(b) Personnel

1. The personnel should stay behind adequate protective barriers during each exposure.
2. When patients must be held or assisted, it is recommended that whenever possible different personnel, particularly non-hospital personnel, perform this service. All such personnel should wear protective aprons and gloves and stand as far out of the beam as possible.

C. *Radiation Therapy*

1. Each installation should be calibrated for output and h.v.l. at least once per year. The area should be monitored for scatter radiation.
2. All personnel in the radiation area should be monitored by film badges.
3. Wherever possible, the patient should be so positioned that the gonads are as great a distance as possible from the direct beam. Shielding should be used if necessary.

III. DENTAL HAZARDS

A. *Equipment and Procedures*

1. The beam should be filtered with 1 to 2 mm. of Al. giving a beam of an h.v.l. of 1 to 2 mm. of Al.
2. A lead slug one mm. thick with an aperture just sufficient to allow the primary beam to cover the dental film should be used as a limiting diaphragm.
3. Film should be held by film holders in the mouth, never by either the patient's or the dentist's fingers.
4. The beam should be directed so that the radiation to other areas of the patient is minimized.
5. Wherever possible, fast film with the appropriate timer should be employed.

B. *Dental Personnel*

1. The dentist should stay outside the primary beam at all times.
2. Wherever possible, the exposure switch should be outside the patient area behind a plaster wall or lead screen.
3. All personnel regularly exposed to radiation should be monitored by film badges and/or pocket dosimeters.

IV. VETERINARY HAZARDS

Since fluoroscopy in veterinary medicine is only rarely necessary and since its hazards are great, it is recommended that radiography be used whenever possible in veterinary medicine.

A. *Radiography Equipment and Procedures*

1. There should be a filter in the beam of not less than 1 mm. of Al.
2. Cones should have an aperture as small as possible to just cover the film used at the required distance.
3. X-rays should be taken utilizing a technic that minimizes exposure to all areas that are not being examined, with particular attention to minimizing gonadal exposure.
4. Whenever the gonads may be exposed in the course of examining an adjacent area, it is recommended that a lead shield or lead rubber apron be used for additional protection.

A. *Veterinary Personnel*

1. The personnel should stay behind protective lead barriers during exposure.
2. When animals must be held or assisted, it is recommended that whenever possible different personnel, particularly non-hospital personnel, perform this service. All such personnel should wear protective aprons and gloves and stand as far out of the beam as possible.

This subcommittee, after interviewing many individuals who use radiation in industry, medicine, veterinary medicine and dentistry, and after discussing methods most effective to reduce unnecessary radiation, has been impressed with the great need to educate all personnel who work with radiation about the hazards and methods for reducing these hazards.

No matter how specifically the regulations are written or how carefully machines are calibrated, unless the individuals working in a radiation area have an understanding of the basic problems of radiologic safety, needless and damaging exposures will occur.

Adopted with the direction that this be made available to all medical practitioners in New Jersey.

Annual Report of the Burlington County Medical Society*

William P. Mulford, M.D., President, Beverly

The year of 1958-59 has been one of transition from a somewhat independent and smaller organization to that of a rather rapidly expanding Society. Most of this will be attributed to a normal increase in population plus the advent of Levittown, N. J. There have been many petty problems concerning this development and these will be disposed of in a proper manner.

The matter of change in policies of one or more paramedical organizations found the local Society ill-informed, uninvited, and obviously slighted in the formulation of new policies concerning the establishment and function of broader concepts for one or more of those paramedical organizations. There was no criticism of the Society's part in the establishment of new policies for one of the paramedical organizations until it concerned the phase of actual medical treatment that such an organization had not previously undertaken. It has become obvious that it will be necessary for honestly interested members of our profession and of the Society to take a more logical participation in the establishment and the continuing function of one or more of the various paramedical organizations. It is hoped that the problems herein incident will not be "lived with" by us but will be particularly "participated in" by us.

In this year we made earnest efforts to establish the best possible general public relations as a local medical society. The several municipal poliomyelitis programs were referred to the example set in Burlington by the local doctors and local municipal government. We have attempted to cooperate, as much as possible, with such organizations as The Welfare Council, The Boy Scouts, and local Service Clubs. We have been particularly interested in the needs of the Red Cross. We offered advice and reasonable participation to the United Fund. The Society is well pleased to have a co-sponsor's role in the establishment of a Community Homemaker's Service in Burlington County.

Our attendance at monthly meetings has been the best that the Society has ever seen. Our scientific programs presented many well-known speakers who imparted to the membership a most enlightening experience. An unfortunate emphasis on the scientific program aspect, however, left the membership little time to discuss important business matters or to thrash out unsolved problems. This will probably be rectified in the ensuing year. The Society, once again, was privileged to hold its annual April meeting at the Deborah Sanatorium in Browns Mills. We are grateful to this institution for its interest in the Burlington County Medical Society.

Once again, our annual combined meeting of the Burlington County Bar Association and the Burlington County Medical Society presented an outstanding panel discussion with a panel moderator, Chester L. Reagan, and our two eminent jurists, Honorable Judge Lester Drenk and Honorable Judge Thomas McGann. These annual meetings have been highly enlightening and have helped to improve doctor-lawyer relationships. We recommend such an annual meeting for all county medical societies.

Our annual Ladies' Night Supper and Dance with the Auxiliary will represent, as usual, our final meeting of the year.

*Received too late for our April issue.

Announcements • • •

Course in Conduct of Deliveries

October 8 through 14, St. Luke's Hospital (New York City) offers a one-week course in "The Conduct of Labor and Delivery." This is for general practitioners. Thirty hours Category I Credit are allowed by the American Academy of General Practice.

The course includes lectures, demonstrations, work in the prenatal and postpartum clinics and assistance in the delivery room. If interested, write to Director, Woman's Hospital, 141 West 109th Street, New York City for details. Enrollment will close on September 15, 1959.

Medical Day at the Shore

July 18 may be a hot Saturday elsewhere but not in the air-conditioned auditorium at Fitkin Memorial Hospital in Neptune. From 9:15 a.m. through 1 p.m. (with an invitation to luncheon) the hospital will be holding a symposium on (1) hypertension, (2) management of fetal distress, (3) pancreatitis, and (4) virus disease. The lecturers are all professors: Columbia, Hahnemann, Georgetown and Johns Hopkins. For further details, write to Dr. Samuel H. Rubin at 1506 Grand Avenue, Asbury Park, N. J.

Board of Obstetrics and Gynecology

Applications for certification (American Board of Obstetrics and Gynecology), Part 1, and requests for re-examination are now being accepted. Deadline for applications is August 1, 1959.

Candidates are requested to write to the Secretary for a current *Bulletin* so that they might be informed as to the present requirements. Application fee ($35.00), photographs, and lists of hospital admissions must accompany all applications. Write to Robert L. Faulkner, M.D. at 2105 Adelbert Road, Cleveland 6, Ohio.

Short-term Courses in Hawaii

The University of Southern California offers a medical graduate course in Hawaii and on board the S. S. *Lurline* from July 29 through August 15, 1959. If you study this way, you will be able to give more concentration than usual to the program because you will be away from the distractions of practice. The teaching-learning process is improved because of the informal relationship that develops among the participating physicians and the faculty.

In addition to lectures, there will be workshops in ECG and x-ray interpretation as well as problems of water and electrolyte balance and the differential diagnosis of jaundice. Programs run simultaneously so that the participating physician may pick and choose the topics most suited to his needs.

Further information is obtained from the Postgraduate Division, USC School of Medicine, 2025 Zonal Avenue, Los Angeles 33, California.

History of Science Award

The History of Science Society has established a $500 annual award, to be given each year for a distinguished contribution to the history of science.

The prize, made possible by Chas. Pfizer & Co., is to be called the Pfizer Award. Selection of the winner will be made by a committee of three scholars.

Chairman of the committee for this year will be Dr. Owsei Temkin, director of History of Medicine at Johns Hopkins University.

For more details, write to History of Science Society, Cambridge 38, Massachusetts, or to Dr. Temkin at Johns Hopkins.

County Society Reports • • •

Gloucester

The *Gloucester County Medical Society* met on March 19 at the Woodbury Country Club.

Dr. DePersia introduced William Perloff, M.D., Director of Endocrinology at Albert Einstein Medical Center, Philadelphia. His topic: "The Pathogenesis of Hirsutism."

Dr. Perloff showed slides, answered questions, and was given a well-deserved rising vote of thanks for his very informative, helpful discussion of a troublesome symptom.

This county society now has a membership of 71. Twenty-six members were present at this March meeting.

Dr. Richard Gotchel's application for membership was read, and upon recommendation of censors was unanimously approved.

Reports were made by chairmen of Legislative and Welfare Committees. Communications were read. Dr. Camp, president, appointed Dr. Campo, Dr. J. Kehler and Dr. Laurusonis as the nominating committee.

Dr. George Rogers, Director of the Gloucester County Guidance Center spoke of the over-load of cases there, and suggested contacting him if any member is interested in a course in psychiatry as a group to aid at the Center.

The meeting was adjourned.

DOROTHY M. ROGERS, M.D.

Reporter

Mercer

The Honorable Charles R. Howell, Commissioner of Banking and Insurance of the State of New Jersey, discussed a report prepared by Professor Sidney I. Simon, Chairman, "New Jersey Blue Cross Study Committee," at the installation meeting of the *Mercer County Component Medical Society*, held Wednesday evening, May 13.

The meeting was under the chairmanship of Dr. Samuel J. Lloyd, President.

Commissioner Howell graciously answered many questions. There was obvious and keen interest by the members in matters pertaining to Blue Cross-Blue Shield problems.

The business portion of the meeting included the presentation of synopses of committee activities during Dr. Lloyd's administration, as president of the Mercer County Component Medical Society; elections to Active membership—Dr. William A. Kressler; Dr. August S. Rivero, on transfer from Camden County Medical Society; Dr. Robert J. Ryan; and Dr. William G. Wosnack, on transfer from Philadelphia County Medical Society; elections to Associate membership—Dr. Robert S. Albahary; Dr. Hans W. Freymuth; and Dr. Rudolph C. Gering; introduction of members elected at the April 8th meeting—Drs. Michaele L. LaPorta, George F. Leibrecht, and Jack L. Ward.

At the conclusion of his term of office. Dr. Lloyd introduced the officers for 1959-1960:

President—Dr. John A. Kinczel
Vice-President—Dr. Peter J. Warter
Secretary-Reporter—Dr. Ralph N. Cagan
Treasurer—Dr. Joseph R. Burns

The following actions were then taken under the chairmanship of President Kinczel:

1. Approval of three bills recently given endorsement by the Trustees of The Medical Society of New Jersey, (S-175, A-607 and A-608). Purpose of these measures is to protect the public from the haphazard and indiscriminate consumer distribution of poisonous and potentially harmful self-medication remedies.
2. The passage of a motion which calls for a meeting, within six months, to discuss Judicial Committee functions at county and state levels.
3. Discussion of details of the Society's picnic, to be held on June 18.

Refreshments were served by members of the Woman's Auxiliary at the conclusion of the meeting.

RALPH N. CAGAN, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by Dr. George J. Kohut, its president, at Roosevelt Hospital, Metuchen, April 15, at 9:00 p.m.

Dr. Bertram Brinsley, Fords, was elected to two years' Associate membership. Dr. Albert Blau, E. I. Du Pont Film Plant, Parlin, was elected to Regular membership by transfer from the Kings County Medical Society.

Dr. B. F. Slobodien, Chairman of the Medical Liability and Insurance Committee said that in order to obtain the new life insurance program, our quota of 79 members enrolled must be met. At this time, we have 29 members enrolled. Dr. Slobodien also stated that the company carrying malpractice insurance coverage might withdraw its policies. The number of law suits for 1959 throughout the entire state has shown a tremendous increase. Suits totalling $20,000,000 are on the docket.

The membership had the pleasure and pride of hearing two papers: "Histopathology of Eastern

Equine Encephalomyelitis" by Dr. Francis J. Warner, New Brunswick and "Doctors of Infamy" by Dr. Fred A. Kessler, Woodbridge. These are original papers written by members of our own Society.

Dr. Kohut read the articles incorporating our county medical society as drawn up by Attorney Francis Seaman. The incorporation and articles were unanimously approved by the members.

The meeting was adjourned.

DONALD T. AKEY, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on April 21 at 9:00 p.m. at the Medical Society Building. Dr. Julian Cohen, First Vice-President, presided in the absence of Dr. Graham.

The following were elected to Active membership: Drs. Jaime Martinez of Passaic and Rafael A. Jacobo of Paterson.

Dr. Cohen informed the members that an article on the Medical-Surgical Plan of New Jersey (Blue Shield) would appear in the May *Bulletin,* along with an application blank. If any member is interested in applying for Blue Shield in this "group" enrollment, he should fill out the application and return it to the Society Office. "Group" enrollment can be effective only if 51 per cent of those eligible apply.

Dr. Cohen reported that a full account of the Passaic County Salk Poliomyelitis Vaccine Committee for mass immunization will be in the May *Bulletin.*

The meeting was then turned over to Dr. Irving Chrisman, Program Chairman, who introduced the guest speaker, Ralph A. Deterling, Jr., M.D., Director of Surgical Research Laboratories, College of Physicians and Surgeons, Columbia University. Dr. Deterling's subject was peripheral vascular diseases. A question period followed.

At the conclusion of the meeting a collation was served at a table attractively arranged in keeping with the April holidays by the hostess, Mrs. Julian Cohen.

DAVID B. LEVINE, M.D.

Reporter

Salem

The *Salem County Medical Society* at its regular meeting on April 17, at the DuPont Penns Grove Country Club, endorsed a uniform program for routine immunization procedures and booster doses. Routine vaccinations will include poliomyelitis, pertussis, tetanus, and diphtheria.

A schedule was developed to illustrate the basic requirements for a proper immunization program.

The panel of officers for the coming year as proposed by the nominating committee was elected unanimously. The officers will be: Drs. George A. Nitsche, Jr., President; Ford A. Spangler, Vice-President; Donald A. McLean, Treasurer; William L. Sprout, Secretary; and George F. Reichwein, Reporter.

Announcement was made of the annual shad dinner to be held at the Salem Country Club on May 16.

Mr. William Smith, president of the Salem County Bar Association led a discussion of the National Interprofessional Code as formulated by the AMA and ABA. This was held to effect a better understanding of the problems confronting lawyers and physicians when medical testimony is required.

Mr. Smith said that only a small proportion of cases on the dockets require the presence of a physician to give testimony. Many settlements are made prior to actual trial.

The usual procedures in securing medical testimony were outlined with regard to depositions, subpenas, affidavits and fees for services. This discussion was very informative and a short question and answer period served to clarify several additional points brought up by Society members.

G. F. REICHWEIN, M.D.

Reporter

Book Reviews

Poisoning: A Guide to Diagnosis and Treatment. W. F. van Oettingen, M.D. Philadelphia 1958. Saunders. Ed. 2. Pp. 627. ($12.50)

What poisons produce an ashy-pale color to the skin? Which ones cause the patient to have a dull and mask-like appearance? In an unusual section on signs and symptoms, Dr. van Oettingen shows what to look for in the poison suspect. He includes signs visible by inspection, laboratory tests and how to do them, and the significance of subjective symptoms. He also presents a handy list of antidotes, notes on how to take a toxicologic history, and a roster of suggestions for equipping a poison center. The individual poisons are then listed alphabetically from albus percatorius and absinthe to zinc and zygadenus with notes on the management of each. All-in-all, this is the best large-volume treatise on toxicology to come out in many years. It will readily earn its keep in the admitting room or library of any hospital and should be well worth shelf space in any general practitioner's office.

FELIX A. UCKO, M.D.

And Then There Were Two: A Handbook for Mothers of Twins. Child Study Association, 132 East 74 Street, New York 21, N. Y. Paper. Pp. 52. ($0.35)

A noticeable gap in the literature on child care is filled by this Child Study Association Release. It offers down-to-earth advice in easy-to-read language and a tone of warmth and understanding with which only one parent can speak to another. Authors of the informative pamphlet are the 125 active members of the Twins' Mothers Club of our own Bergen County who wrote it on the basis of their experiences and trial-and-error findings.

Says A. B. Buchmueller, Director of the Association: "In publishing this pamphlet we are stepping out of our traditional role of selection and interpretation to act simply as entrepreneur. It is a departure for us and a pleasure to open another channel through which one parent can speak to another with the freshness and validity of first-hand experience."

Dr. George Heller, President of the Bergen County Medical Society, who has written the introduction, says: "New parents of twins will find this little book practical, instructive, even amusing in spots. It takes up where Spock leaves off and will lend much reassurance at a trying time."

Chapters include: Some Facts About Twins; Adjustments Within the Family; Clothing and Equipment; What Can Father Do?; Breast-Feeding Twins; Toilet Training; Twins' Development; What It Means to Be a Twin; Emotional Problems; School Problems; Traveling with Twins; What to Name Your Twins?; The How of a Twins' Mothers Club.

If you ever deliver a pair of twins, you can make a hit with the family by presenting the parents with this booklet. You will rarely be able to buy so much good will for 35 cents.

RALPH N. SHAPIRO, M.D.

Services for Children with Epilepsy: A Guide for Health Personnel. American Public Health Association. New York 1958. Paper. Pp. 124. ($1.50)

Without undervaluing the importance of medical treatment, this book constantly emphasizes the psycho-social aspects of epilepsy. Stress is laid upon the desirability of as near normal living as possible for the epileptic, with appropriate educational, vocational and social planning. The families, teachers and peers of the epileptic child become nearly as important as the patient himself. Realism and forthrightness are urged for all concerned, in addition to the necessary understanding and support. A problem much broader than its specific application here is stated with characteristic simplicity as the directions for research are discussed, "It has become apparent, however, that unless research in sociology, psychology, education and public health can keep pace with medical research, there will be gaps in understanding and lags in services."

This is a highly readable, densely packed little volume, of interest to the layman, value to the profession, and urgency for those concerned with community planning.

PRISCILLA ROLFE

Youthful Offenders at Highfields. By H. Ashley Weeks. Ann Arbor 1958. University of Michigan Press. Pp. 208. ($6.00)

Highfields, situated on the former Lindbergh estate at Hopewell, N. J., is a residential center for the rehabilitation of juvenile offenders. It differs from the traditional reformatory by offering a non-institutional atmosphere, a small population, short-term stay, and therapy through group interaction sessions.

At the time of its inception, the Highfields project included a research study to evaluate its program. This book reports the statistical findings. It is written in a style both heavy and pedantic, heavily weighted with tables and charts. The statistical evaluations seem unending and appear repetitive. The differences between Highfield boys and those at Annandale (the traditional reforma-

tory which was used as a control group) often cancel each other out as do many of the results. Mr. Weeks' comments will prove bewildering to the reader unsophisticated in statistical appraisals, as the author explains away most of the significant findings in terms of variables other than the ones measured. The most interesting evaluation and comparison of the Highfield boy and the Annandale boy, a psychological report by the late Dr. J. Quinter Helsopple, is of little value since it deals with group findings and not individual reports which could have been related to individual successes and failures. A qualitative analysis of each boy might have been of greater predictive value and of greater interest The program has been particularly successful with Negro offenders, but we do not know why nor do we know what facet of the Highfield experiment has been responsible for this success.

To this reviewer, it appears that this book emphasizes the ambiguity and lack of practical use of statistical analyses of human problems and human solutions. Even if an occasional jewel of a fact does appear, the reader cannot find it again because of the editor's maddening failure to provide an index.

LILLIAN L. WEINBERGER, M.A.

Lesions of the Lower Bowel. By Raymond J. Jackman, M.D., Springfield, Illinois 1958, Charles C Thomas. Pp. 388, illus. 131. ($15.50)

The internal, intramural and external lesions of the lower bowel are only briefly discussed in most of the textbooks on proctology. This book therefore fills a long felt need. Dr. Jackman evaluates the findings in 350,000 cases treated at the Mayo Clinic over a twenty-year period. Diagnosis rather than therapy is emphasized. Reference is made to accepted forms of treatment, without entering into a discussion of therapeutic technics. Controversial subjects are evaluated in the light of newer concepts. The author advocates digital examination before introduction of an instrument into the rectum. He emphasizes, however, that proper diagnosis is dependent on proctoscopic and proctologic examination. Roentgenologic studies are of little value except in cases of presacral masses, and in examination of the large bowel beyond the range of the proctoscope.

Diagnostic procedures are fully described and beautifully illustrated. The colored views of conditions seen through the sigmoidoscope, as well as the illustrations of presacral tumors and submucosal nodules are most helpful. About one-third of the book is devoted to differential diagnosis of benign and malignant growths. Of particular value is the author's discussion of personal experiences with unusual situations. The book will prove of value to the general practitioner, internist and diagnostician as well as to the proctologist and surgeon, who will want a copy at hand for ready reference

GEORGE L. BECKER, M.D.

Symposium on Special Diagnostic Aids and Symposium on Abnormal Uterine Bleeding. September 1958 bound issues of Clinical Obstetrics and Gynecology. Paul B. Hoeber, Inc. Pp. 303.

This is the third issue of the unique two-in-bound books of the "Clinical Obstetrics and Gynecology" series. The first half is edited by C. P. Hodgkinson and covers such diagnostic aids as cytology, peritoneal washings, culdocentesis, the gynogram, placentography, culdoscopy and cystometry. The second half, edited by John Brewer, discusses abnormal uterine bleeding. The text is concise, useful and nicely illustrated. Altogether a pair of superior monographs!

JOSEPH HOCHSTADT, M.D.

Cholesterol as Related to Atherosclerosis: Review of the Literature 1950-7. Prepared by Helen I. Mattill, Ph.D. Published 1958 by the Cereal Institute, Chicago. Pp. 67. Paper. Price not stated.

No longer is it necessary for the physician to submit to the confusion of such awesome things as the role of saturated and unsaturated fatty acids and alpha and beta lipoproteins in the production of atherosclerosis or the significance of coronary attack rates in South African natives and Eskimos.

Now in a concise, readable report all of the diverse information concerning cholesterol as related to atherosclerosis has been gathered.

This convenient paper-bound report is a God-send to those who don't have time enough to read the voluminous literature and to those who need a readily available and exhaustive bibliography concerning the problem.

PETER O. GARNER, M.D.

Reversicon: A Medical Word Finder. J. E. Schmidt, M.D. Springfield, Illinois 1958. Charles C Thomas. Pp. 440. (Price not stated)

It's about time somebody wrote a book like this. You have a medical concept—but what's the word for it? Someone who focuses his sex interest on hair. What's he? Look under "focussing of sex interest"—and there you have it: trichocentric. What's an organism whose temperature remains uniform (like you and me)? A homotherm. And so on. Idea first—word next. In all, some 25,000 entries. And you have a choice of several words for some of the ideas. A unique treasury this—one which will more than earn shelf-space in the home or office of any literate doctor.

HENRY A. DAVIDSON, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JUNE, 1959 • VOL. XXXII, No. 6

TUBERCULOSIS AND THE FAMILY PHYSICIAN

The modern treatment of tuberculosis outlined here places the family physician in the key position. The tools and services of the tuberculosis hospital should be available to him.

The family physician traditionally has played a larger role in the diagnosis of tuberculosis than in its treatment. Recently, however, tuberculosis has become a much more manageable disease, and the need for long-term institutional care has been sharply curtailed. Even if one agrees that almost all cases of tuberculosis are to be hospitalized at the beginning, the family physician can and should take a larger part in the treatment and clinical management of these patients than he has in the past.

Tuberculosis still is not an easy disease to treat nor is the treatment routine. There are many varieties of tuberculosis. It is not enough to identify the location of tuberculosis lesions, but one must also know whether these lesions consist predominantly of inflammatory elements or whether necrosis is advanced and cavitation is present and to what extent reparative changes already have taken place. Prognosis in the antimicrobial era depends more on the duration of tuberculous disease before treatment is started than on its extent. If treatment is prompt and adequate in the early stages of acute cases, one can expect almost complete resolution of pneumonic patches and prompt closure of even large cavities.

In hospitalized patients strict bed rest appears to be unnecessary. In severe tuberculosis with acute symptoms it is more important to begin drug treatment promptly than it is to have the patient admitted promptly to a hospital. This assumes that the diagnosis has been confirmed and that the drug regimen selected is adequate. But unless the patient is markedly prostrated and debilitated or has hemoptysized, he does not require strict bed rest or much nursing care. Rather, it is for the protection of his contacts and of the public and for other ancillary objectives that a period of hospitalization usually is advisable.

CARL MUSCHENHEIM, M.D., *New York State Journal of Medicine, December 15, 1958.*

DRUG REGIMEN

An adequate drug regimen for initial treatment should include isoniazid, the most potent of the available therapeutic agents. This may be coupled with either streptomycin or para-aminosalicylic acid (PAS). The use of two drugs is customary, although there is evidence that in noncavitary pulmonary tuberculosis and in certain types of extrapulmonary tuberculosis isoniazid alone is adequate. PAS is the more commonly used companion drug, but in miliary or meningeal tuberculosis and in severe pneumonic forms, streptomycin, the most potent drug, is available. If streptomycin is used, it should be given daily, in doses of 1 gm. intramuscularly, at least during the first month or two. Regular streptomycin, rather than dihydrostreptomycin, is the drug of choice because of the considerably greater auditory toxicity of the dihydro derivative. The usual oral dosage of isoniazid is 5 mg. per kg. per day or for adults an average of 300 mg. total daily dose, divided in two or three individual doses of 150 mg. or 100 mg. PAS usually is given orally in a total daily dose of 12 gm., divided in three or four individual doses with meals. Children tolerate these drugs better than adults do and may receive larger proportionate doses.

In most forms of tuberculosis, surgery is rarely necessary, at least until after several months of conservative antimicrobial therapy. Progress in pulmonary tuberculosis should be gauged adequately by periodic chest films and regular sputum or gastric cultures at monthly intervals. If clinical progress is satisfactory, it is best to adhere to the same drug regimen despite any in vitro evidence of drug resistance.

TOXICITY OF DRUGS

Changes in therapy are most often dictated by manifestations of drug toxicity. Isoniazid is the least frequent offender, PAS the most poorly tolerated because of gastrointestinal disturbances, and streptomycin the most carefully to be watched because of the potential serious damage to the eighth nerve and because of its potential nephrotoxicity as well. Streptomycin should not be used in full dosage when there is any evidence of reduced kidney function, or in the elderly except for most compelling indications. Sometimes it is necessary to have recourse to the second line of antituberculous drugs, which include viomycin, cycloserine, and pyrazinoic acid amide. These may be useful in older, previously treated, chronic, inoperable cases.

In the initial course of treatment, it is now usually possible to bring the case to a successful outcome provided (1) the drug therapy is uninterrupted, (2) any ancillary surgical procedures be performed at the proper time, and (3) the drug therapy is continued for a sufficiently long time. The duration of therapy should never be less than one year, and for most types of tuberculosis it should be up to two or three years. Treatment with isoniazid alone is usually sufficient after the first year or six months after surgery if bacteriologic conversion of body secretions, such as sputum, gastric washings, or (in the case of renal tuberculosis) the urine, has been attained. Healing or surgical excision of open lesions also should have taken place before the drug therapy is simplified to the single drug, isoniazid.

It is clear from this outline of a therapeutic program, that most newly diagnosed cases can be managed for the greater portion of the period of active treatment outside of hospitals. The initial period of hospitalization will rarely need to be for longer than six or eight months, and often a few weeks will suffice.

SURGERY

The salient fact which has emerged in the last few years is that the indications for surgery in tuberculosis are diminishing. The incidence of relapse following successful and long-continued medical therapy is proving to be remarkably low. The results of conservative treatment of renal tuberculosis have been so successful that the indications for nephrectomy in this disease can with little justification be considered absolute or urgent. Only in renal tuberculosis is there any evidence that simultaneous administration of all three standard drugs (isoniazid, streptomycin, and PAS) is advantageous.

The policy of deferring surgical procedures on the treatment of bone and joint tuberculosis until after several months of chemotherapy is becoming increasingly important. In other "surgical" forms of tuberculosis, such as the tuberculosis of superficial lymph nodes, the surgery is best delayed in most cases.

From the foregoing outline it is evident that much of the responsibility for the therapeutic program must increasingly fall on the family physician. What tools will the family physician need beyond those he can provide in his office? He will need to have access to all the tools which are now provided in tuberculosis hospitals. He will need to have a cooperative liaison with inpatient hospital services. Coordination between the hospital and home phases of management is essential.

The communicability of tuberculosis is still a paramount consideration. Tuberculosis never can be treated casually or without regard to the health of others. The relationship is, in its very essentials, not merely between the physician and the patient but between these two and the entire community.

NEW JERSEY TRUDEAU SOCIETY
is the medical section of
NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
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Dosage: One tablet three times a day.

Availability: Aqua-colored tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride). G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

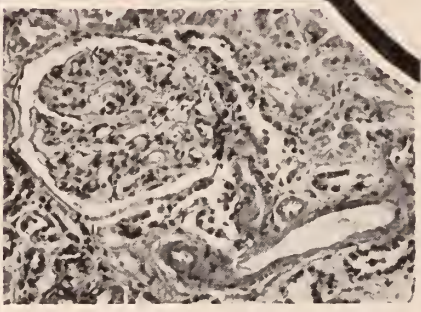
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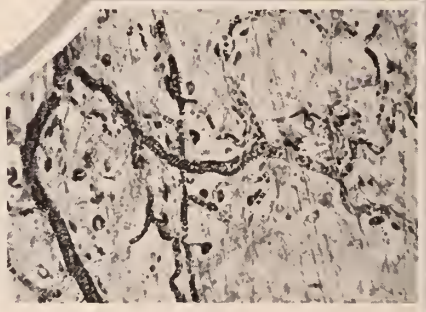
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Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.

References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

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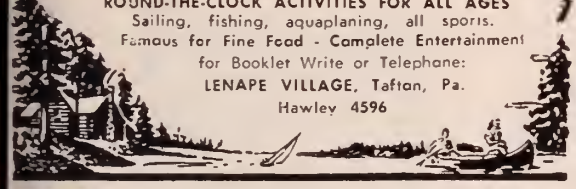
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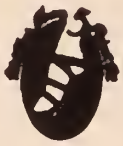
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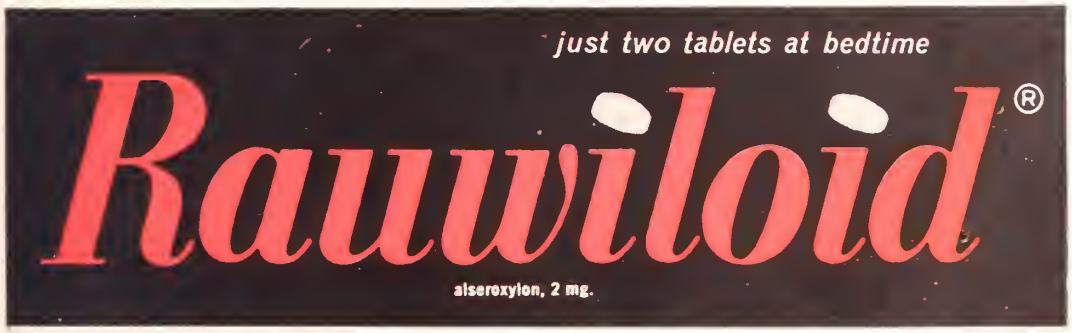
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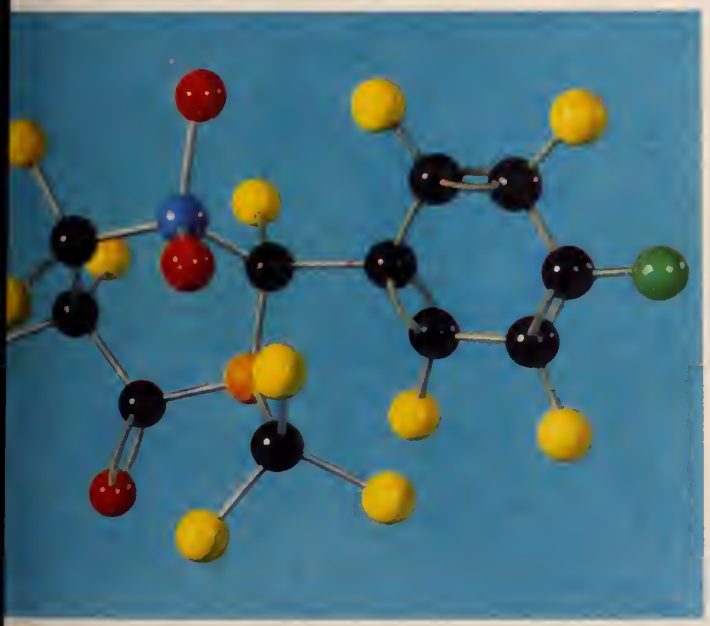
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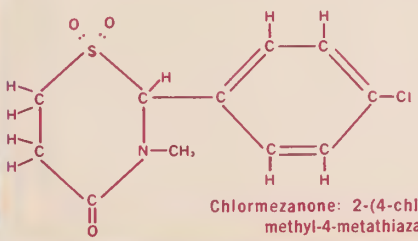
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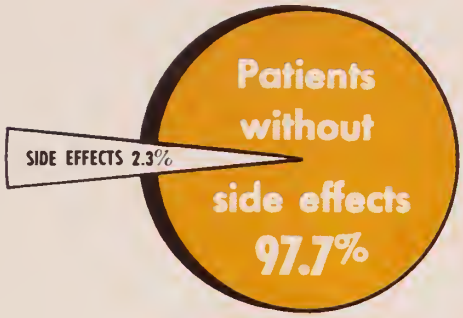
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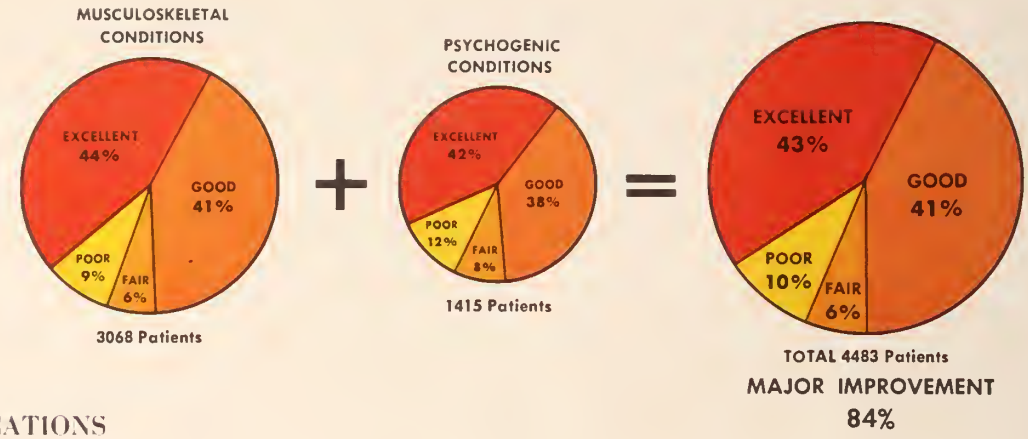
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References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. • 2. Ganz, S.E.: J. Indiana M. A. In press. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

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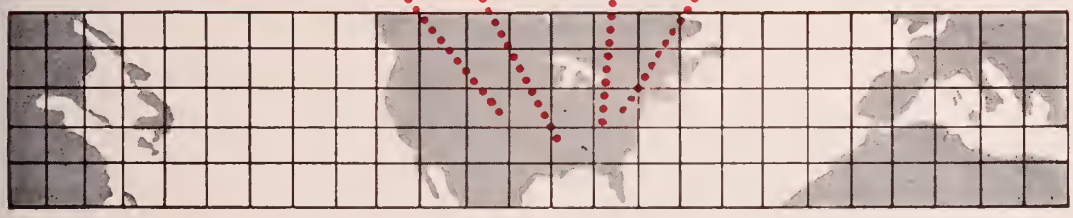
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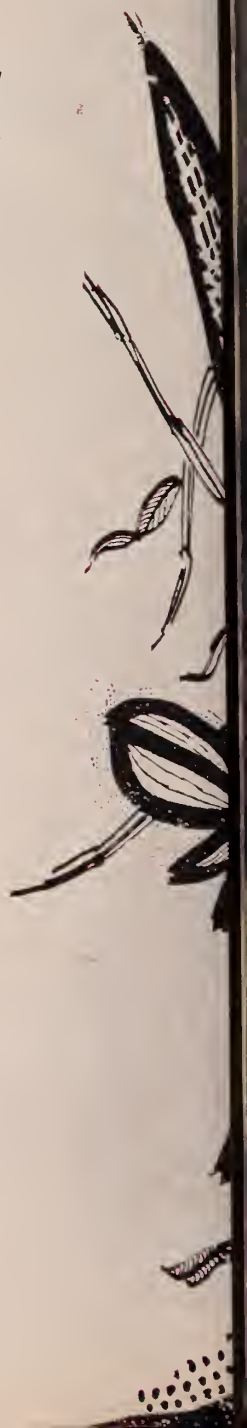
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CONTENTS—Pages 363 to 480

EDITORIALS— Page

If Engineers Were Plastic Surgeons ... 363
Geriatrics and Blue Shield ... 364

STATE ACTIVITIES—

Trustees' Meetings ... 365
Welfare Committee ... 367
Liability Insurance for Institutional Physicians 370
Dr. Tarbell's Retirement ... 371
Request from State Board of Medical Examiners ... 371
Ob-Gyn Diplomates ... 371
Scientific Exhibit Awards ... 372
Attendance at 1959 Annual Meeting ... 372

Page

OBITUARIES ... 373
ANNOUNCEMENTS ... 374
COUNTY SOCIETY REPORTS ... 375
BOOK REVIEWS ... 378

TRANSACTIONS OF THE HOUSE OF DELEGATES—

Index ... 379
Annual Reports ... 380
Revision of Constitution and Bylaws ... 429
Resolutions ... 454
Medical Service Administration ... 459
Medical-Surgical Plan ... 463
Reference Committee Reports ... 470
Nominations and Election ... 479
President Gardner's Address ... 480

Roster of Officers and Committee Chairmen, Advertising Page 3A

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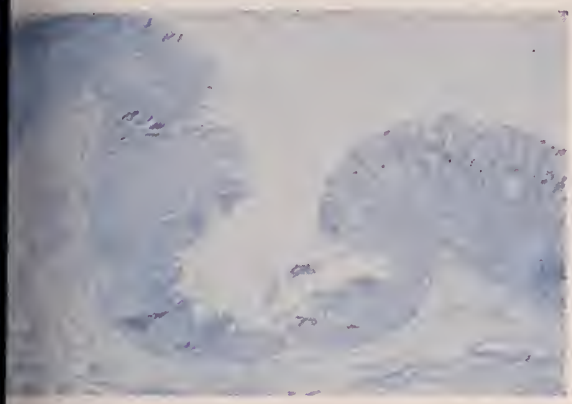
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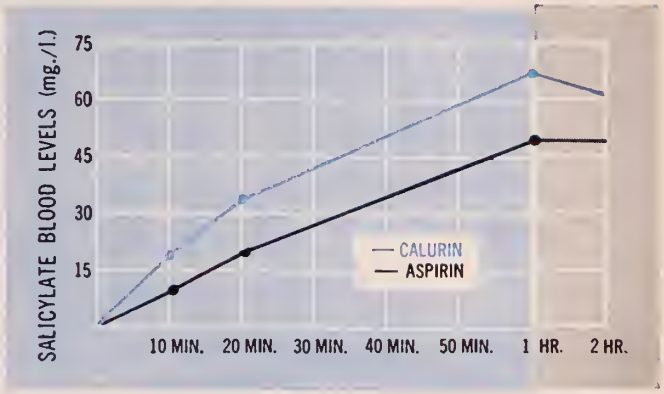
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dosage: for "round-the-clock" control — 10 mg. to 25 mg., b.i.d.; for "once-a-day" use — 25 mg. once a day, appropriately scheduled, for therapy or prevention. **supply:** Oral Tablets, 10, 25 and 50 mg., press-coated, bottles of 50 and 500; Emulsion (Vesprin Base) — 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). **references:** 1. Stone, H.H.: Monographs on Therapy *3*:1 (May) 1958. 2. Reeves, J.E. Postgrad. Med. *24*:687 (Dec.) 1958. 3. Burstein, F.: Clinical Research Notes *2*:3, 1959. 4. Kris, E.: Clinical Research Notes *2*:1, 1959. VESPRIN is a Squibb Trademark

Vesprin—the tranquilizer that fills a need in every major area of medical practice

SQUIBB
Squibb Quality—
the Priceless Ingredient



Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

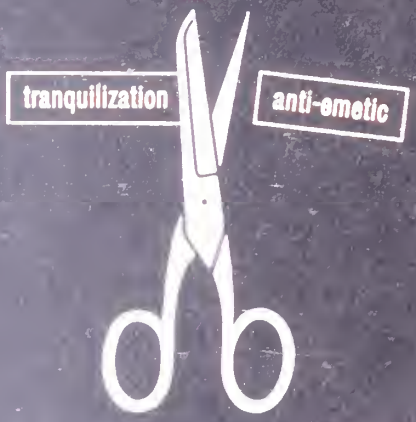
Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.

now potent tranquilizer therapy is safer than ever



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

- **jaundice**
- **Parkinsonism**
- **blood dyscrasia**

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."†

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatit even when given in quantities far in excess of the usual dosage.

"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responded to reduction in dosage. Other side effects did not occur.. It is singularly free from the side effects ordinarily se with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common aft administration of the phenothiazines, was present duri the period of Thioridazine administration: Parkinso ism or Parkinson-like symptoms, photosensitivity, orth static hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

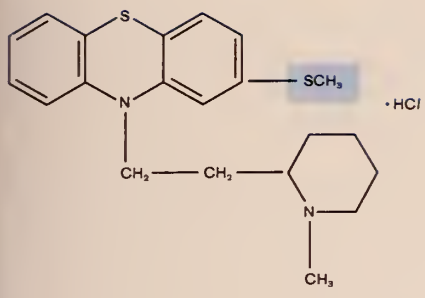
"Side effects such as extrapyramidal activity, jaundi and photosensitivity have not been observed in patien treated with Thioridazine [Mellaril]. Extrapyramid side effects produced by other phenothiazines ha disappeared promptly with no deterioration in the b havioral response when these patients have been shift to Thioridazine."[5]

NO JAUNDICE

"No allergic reactions were observed such as skin eru tions, jaundice or agranulocytosis. Central nervo system toxicity, as manifested by extrapyramidal effec seizures, and excitement did not occur despite the u of high doses (up to 2000 mg.) of the drug."[6]

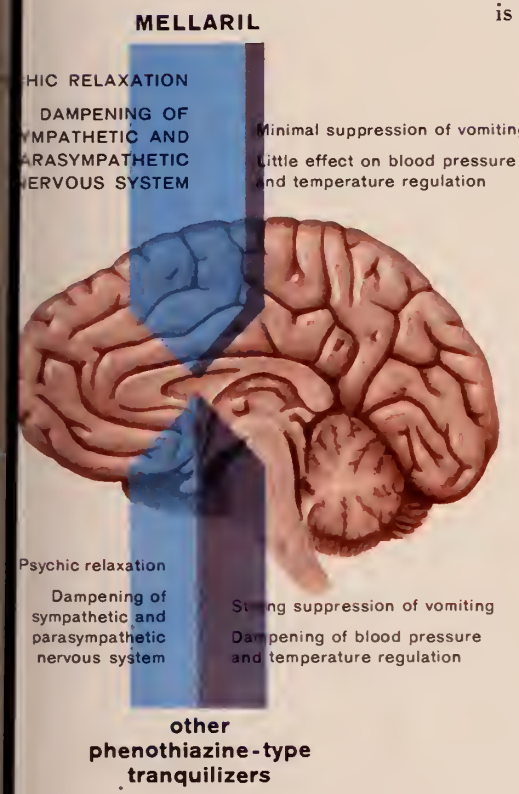


new advance in tranquilization:
eater specificity of tranquilizing action plus fewer side effects



Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical ($S\text{-}CH_3$) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.





2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

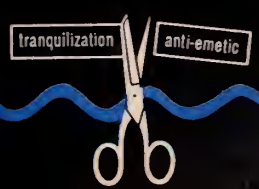
5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to mg. three times a day may be administered.

Dosage must be individualized according to the co tion and degree of response. In all cases, the smal effective dosage should be determined for each pati

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
	ADULTS	
Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
	CHILDREN	
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemop depression, jaundice or orthostatic hypotension. A other phenothiazines, Mellaril is contraindicat severely depressed or comatose states from any cau

SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical ation, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, A Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Sc Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (M in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 2

- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

SAN

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

tranquilization | anti-emetic

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

‡ **ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.**

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Just a "poof" of fine **NTZ** *spray brings relief* IN SECONDS, FOR HOURS

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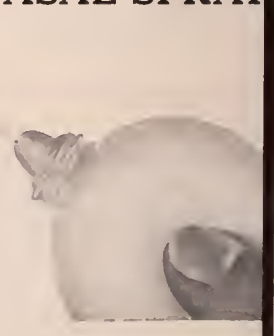
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Therapy with DECADRON has also been distinguished by virtual absence of diabetogenic effects and hypertension, by fewer and milder Cushingoid reactions, and by freedom from any new or "peculiar" side effects. Moreover, DECADRON has helped restore a "natural" sense of well-being.

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. . . in nearly all external symptoms of *pain*, *itching* and *burning*, e.g., sunburn, minor burns, insect bites, abrasions, poison ivy and other contact dermatitis, hemorrhoids and inoperable anorectal conditions, and cracked nipples.

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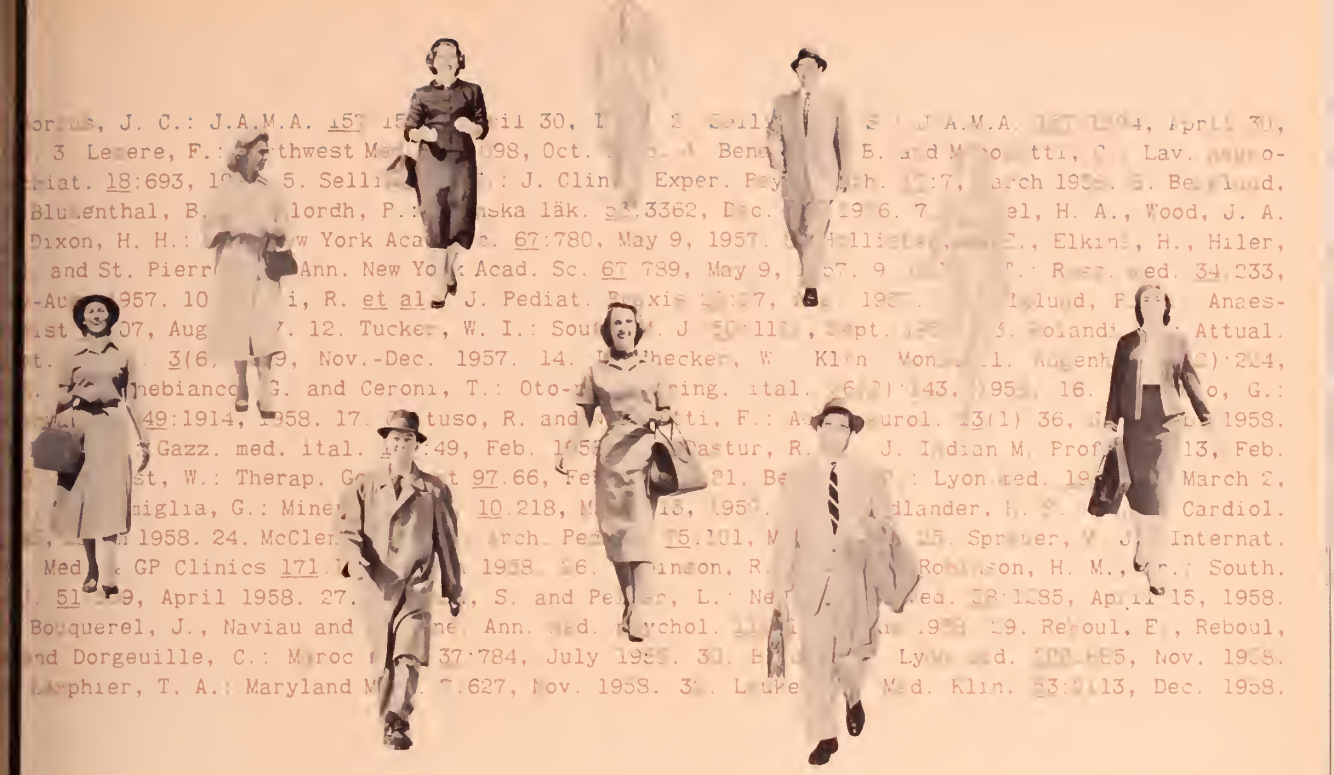
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70-95%*

of nervous, tense patients recovered or improved

For your patients, Miltown promptly checks emotional and muscular tension. Thus, you will make it easier for them to lead a normal family life and to carry on their usual work.

For you, the choice of Miltown as the tranquilizer means the comfortable assurance that it will relieve nervousness and tension without impairing your patient's mental efficiency, motor control, normal behavior or autonomic balance.

meprobamate (Wallace)

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Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

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Through effective relief of anxiety, irritability, insomnia and tension, Miltown aids the patient to "live with his disease," especially during difficult adjustment periods.

Miltown is well tolerated and *"therefore well suited for prolonged treatment in chronic disorders with emotional complications."* (Friedlander, H. S.: Am. J. Cardiol. *1*:395, March 1958.)

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meprobamate (Wallace)

Available in 400 mg. scored and 200 mg. sugar-coated tablets; bottles of 50. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules) and MEPROTABS* (400 mg. *unidentifiable,* coated meprobamate tablets).

When mental depression complicates chronic disease: DEPROL* (1 mg. benactyzine HCl plus 400 mg. meprobamate). *TRADE-MARK

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. . . the preferred drug where anxiety or emotional agitation must be controlled

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. . . double assayed to insure optimal therapeutic effect

tested chemically to insure total alkaloid content

tested biologically to insure uniform hypotensive action

. . . ideal therapy in labile and moderate hypertension or as odjunctive therapy in severe hypertension

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- ✓ Curbs excessive peristalsis
- ✓ Adsorbs toxins and gases
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- ✓ Provides intestinal antisepsis

FORMULA:

Each 15 cc. (tablespoon) contains:

Sulfoguonidine	2 Gm.
Pectin	225 mg.
Koolin	3 Gm.
Opium tincture	0.08 cc.
(equivolent to 2 cc. poregoric)	

SUPPLIED:

Bottles of 16 fl. oz.
Exempt Narcotic.
Available on Prescription Only.

DOSAGE:

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

CHILDREN: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

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Ointment: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

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If one . . . or all . . . needs nutritional support . . .



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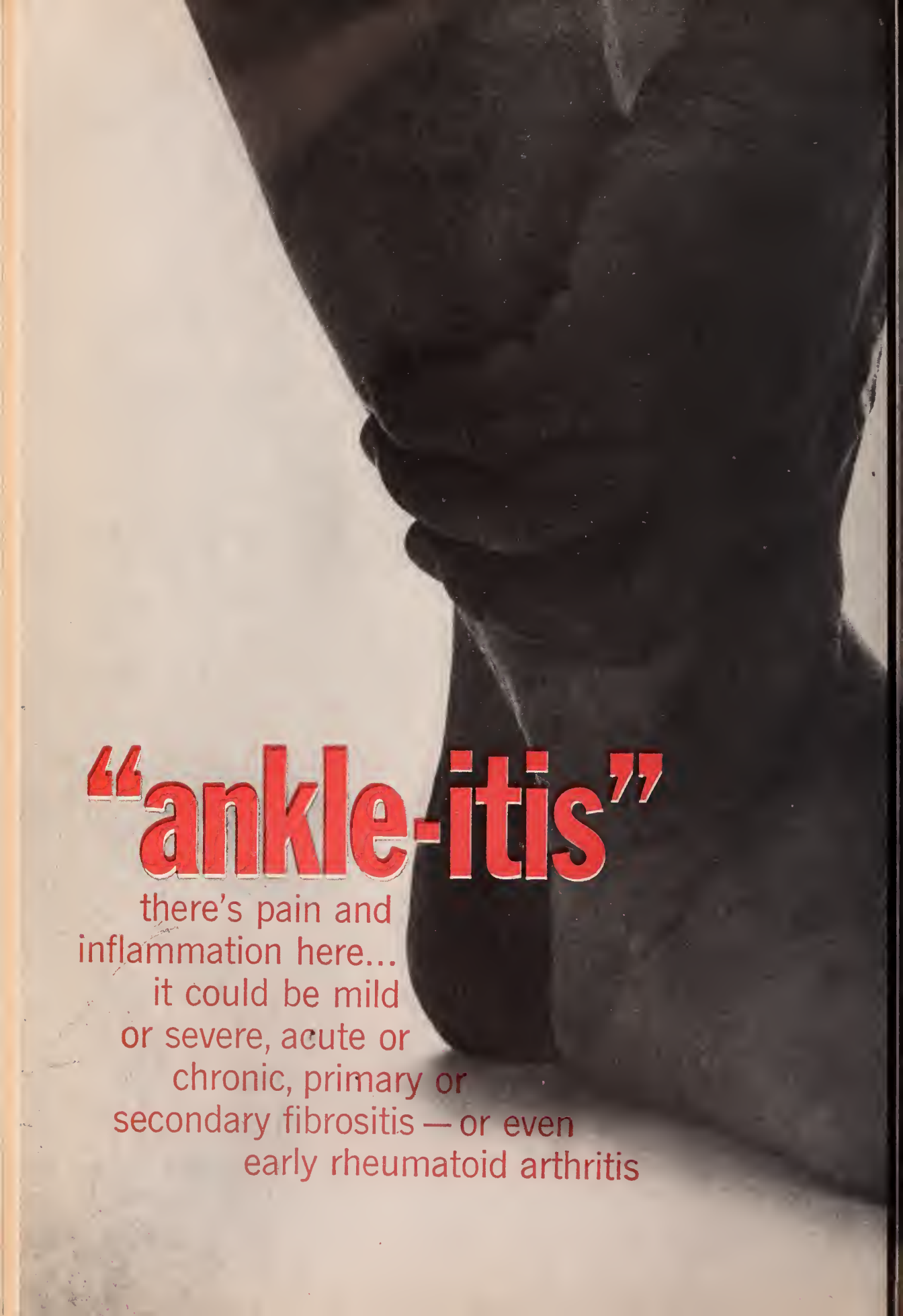
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For Complete Formula see PDR (Physicians' Desk Reference), page 689

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Lederle


"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
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early rheumatoid arthritis

e potent and comprehensive treatment salicylate alone

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e conservative and manageable than full- ge corticosteroid therapy—

less likelihood of treatment-interrupting effects[1-6] . . . reduces possibility of residual y . . . simple, flexible dosage schedule

APY SHOULD BE INDIVIDUALIZED

conditions: Two or three tablets four times daily. After d response is obtained, gradually reduce daily dosage hen discontinue.

ute or chronic conditions: Initially as above. When sat- ory control is obtained, gradually reduce the daily e to minimum effective maintenance level. For best s administer after meals and at bedtime.

utions: Because SIGMAGEN contains prednisone, the precautions and contraindications observed with this d apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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VERTIGO

Each ANTIVERT *tablet contains:*

Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.[1]

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.[2,3]

Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."[2]

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics *2*:110 (March) 1956. 2. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America *40*:1787 (Nov.) 1956.

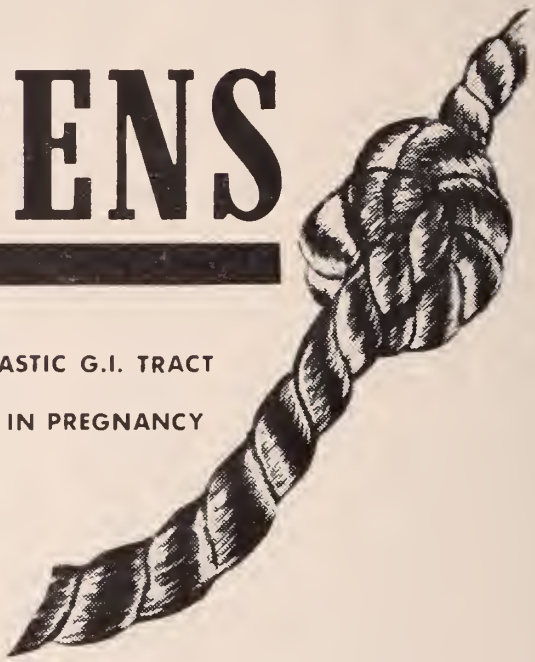
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TY-MED*



- FOR RELAXING THE SPASTIC G.I. TRACT
- FOR RELIEF OF NAUSEA IN PREGNANCY

Each Tablet Contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

DOSAGE: 1 tablet morning and night

CAUTION: Federal law prohibits dispensing without prescription.

*Ty-Med—Lemmon Brand of Timed-Release Medication.

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TIMED-RELEASE . . . AT ITS LEVEL BEST



when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1,2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough:* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

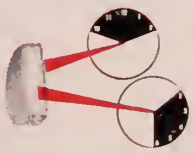
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4,5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6,7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. 11:165 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19 19 (Jan.) 1918. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

Triaminic®

TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.



Each TRIAMINIC timed-release tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

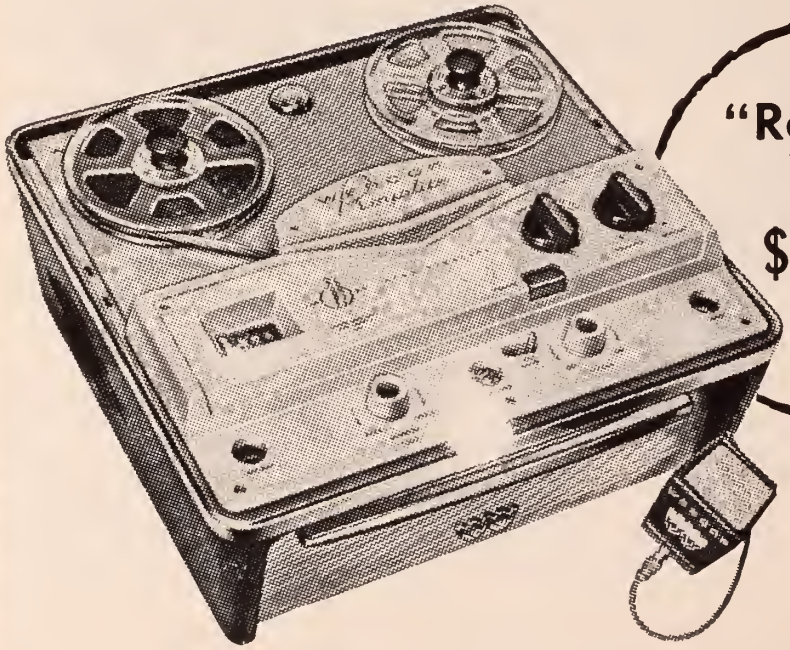
Also available: TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.

STOP *running noses* *and open stuffed noses orally*

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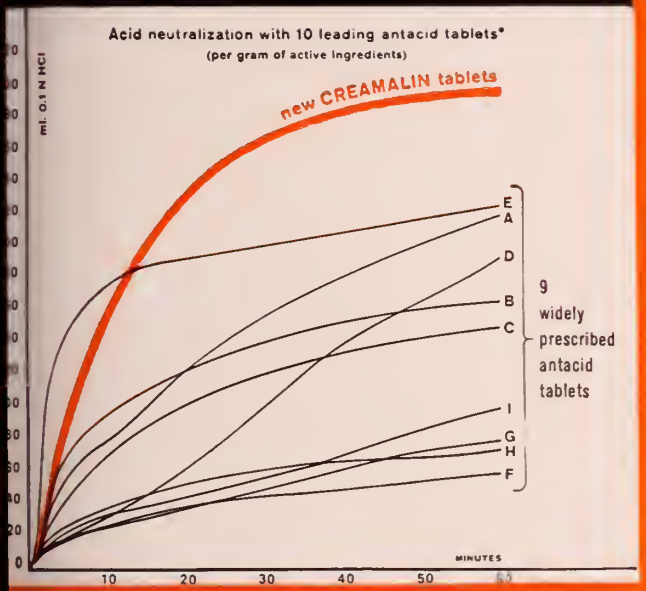
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CREAMALIN NEUTRALIZES *MORE* ACID *FASTER*

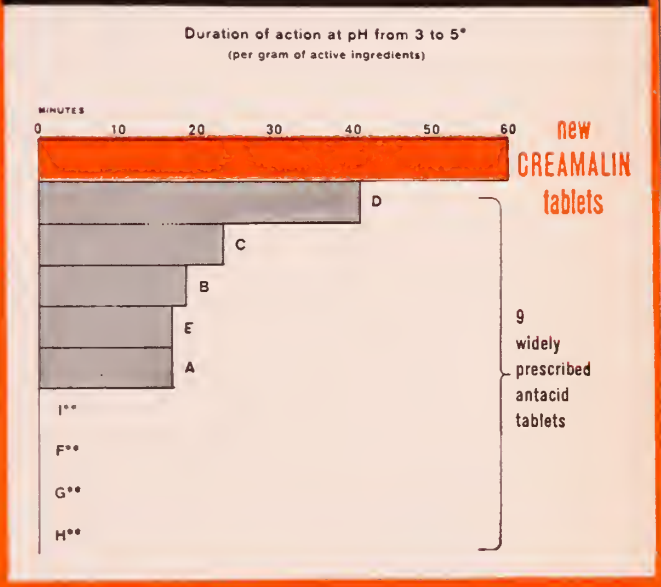
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were powdered and suspended in distilled water in a constant temperature r (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric d was added as needed to maintain pH at 3.5. Volume of acid required was ed at frequent intervals for one hour.

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More Lasting Relief



*Hinkel, E. T., Jr., Fisher, and Tainter, M. L. A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.

ch Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short poly- r dried aluminum hydroxide gel, (stabilized with hexitol), with 75 mg. magnesium hydroxide.

1. *Neutralizes acid faster (quicker relief)*
2. *Neutralizes more acid (greater relief)*
3. *Neutralizes acid longer (more lasting relief)*
4. *No constipation • No acid rebound*
5. *More pleasant to take*



o chalky taste. New CREAMALIN tablets are not alky, gritty, rough or dry. They are highly pal- able, soft, smooth, easy to chew, mint flavored.

Adult Dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

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LOW BACK PAIN

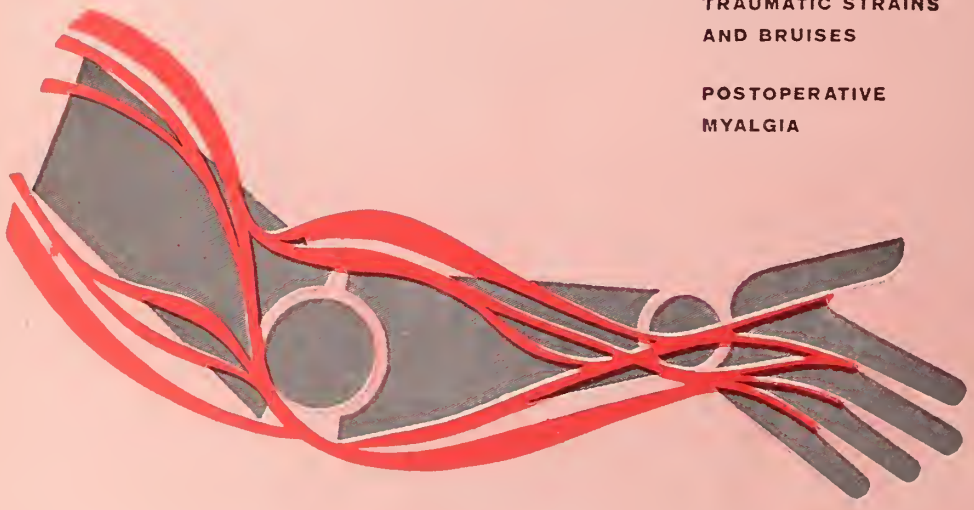
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■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

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SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with any previously used analgesic, sedative or relaxant drug.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

Literature and samples on request.

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In recognition of the responsibility of the pharmaceutical industry to aid postgraduate medical education, Lederle originated its Symposium Program eight years ago. Initiated with a meeting sponsored by the Knoxville Academy of Medicine and continued with other medical organizations, the program presents up-to-date information of clinical significance to physicians throughout the United States and Canada. Through Symposia, over 50,000 physicians have had the opportunity to hear and question specialists in every field and, with their wives, participate in the activities of a Symposium day.

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BEAUMONT, TEXAS—Saturday, September 19, 1959
The Hotel Beaumont

KANSAS CITY, KANSAS—Friday, September 25, 1959
Battenfeld Memorial Auditorium

INDIANAPOLIS, INDIANA—Wednesday, Sept. 30, 1959
The Sheraton-Lincoln Hotel

OKLAHOMA CITY, OKLAHOMA—Friday, October 2, 1959
The Skirvin Hotel

BIRMINGHAM, ALABAMA—Sunday, October 11, 1959
The Dinkler-Tutwiler Hotel

TACOMA, WASHINGTON—Wednesday, October 14, 1959
The Hotel Winthrop

TRAVERSE CITY, MICHIGAN—Friday, October 23, 1959
The Park Place Hotel

LUBBOCK, TEXAS—Saturday, October 31, 1959
The Lubbock Country Club

ST. CHARLES, ILLINOIS—Wednesday, November 4, 1959
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DALLAS, TEXAS—Friday, November 6, 1959
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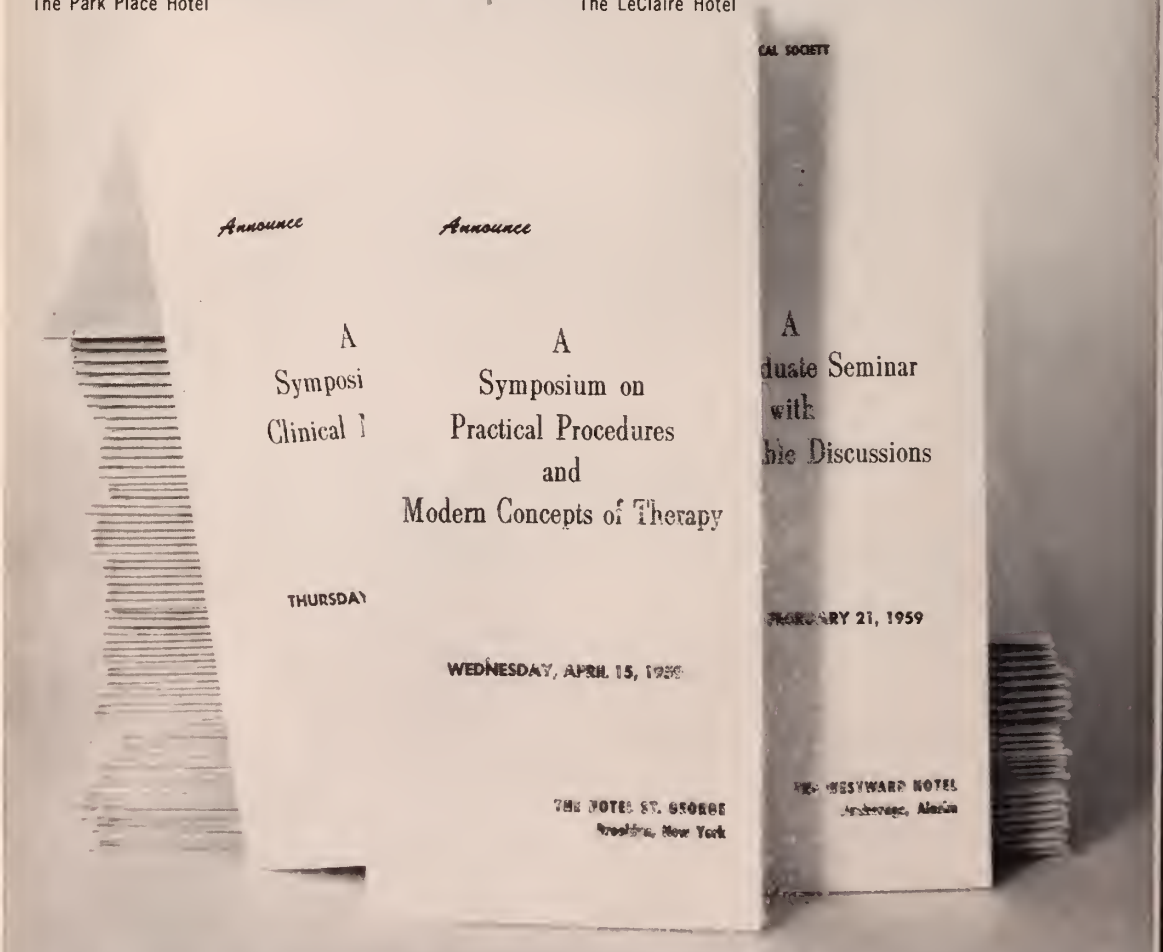
SCHENECTADY, NEW YORK—Thursday, November 12, 1959
The Mohawk Golf Club

CORPUS CHRISTI, TEXAS—Friday, November 13, 1959
The Robert Driscoll Hotel

RIVERSIDE, CALIFORNIA—Sunday, November 15, 1959
The Mission Inn

SANTA BARBARA, CALIFORNIA—Wednesday, Nov. 18, 1959
The Santa Barbara Biltmore

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for most of your diabetic patients

DBI

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RESEARCH:

key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.



The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!



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Actually prevents
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A better, safer cleanser
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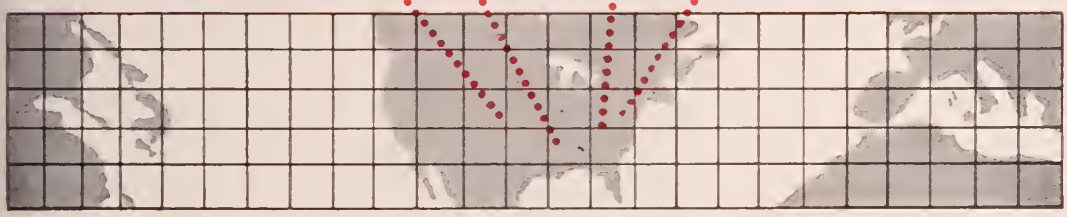
(brand of hydroxyzine)

IN GERIATRICS
"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

IN GENERAL
ATARAX IS "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d.
	Syrup	3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets	one tablet q.i.d.
	Syrup	one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

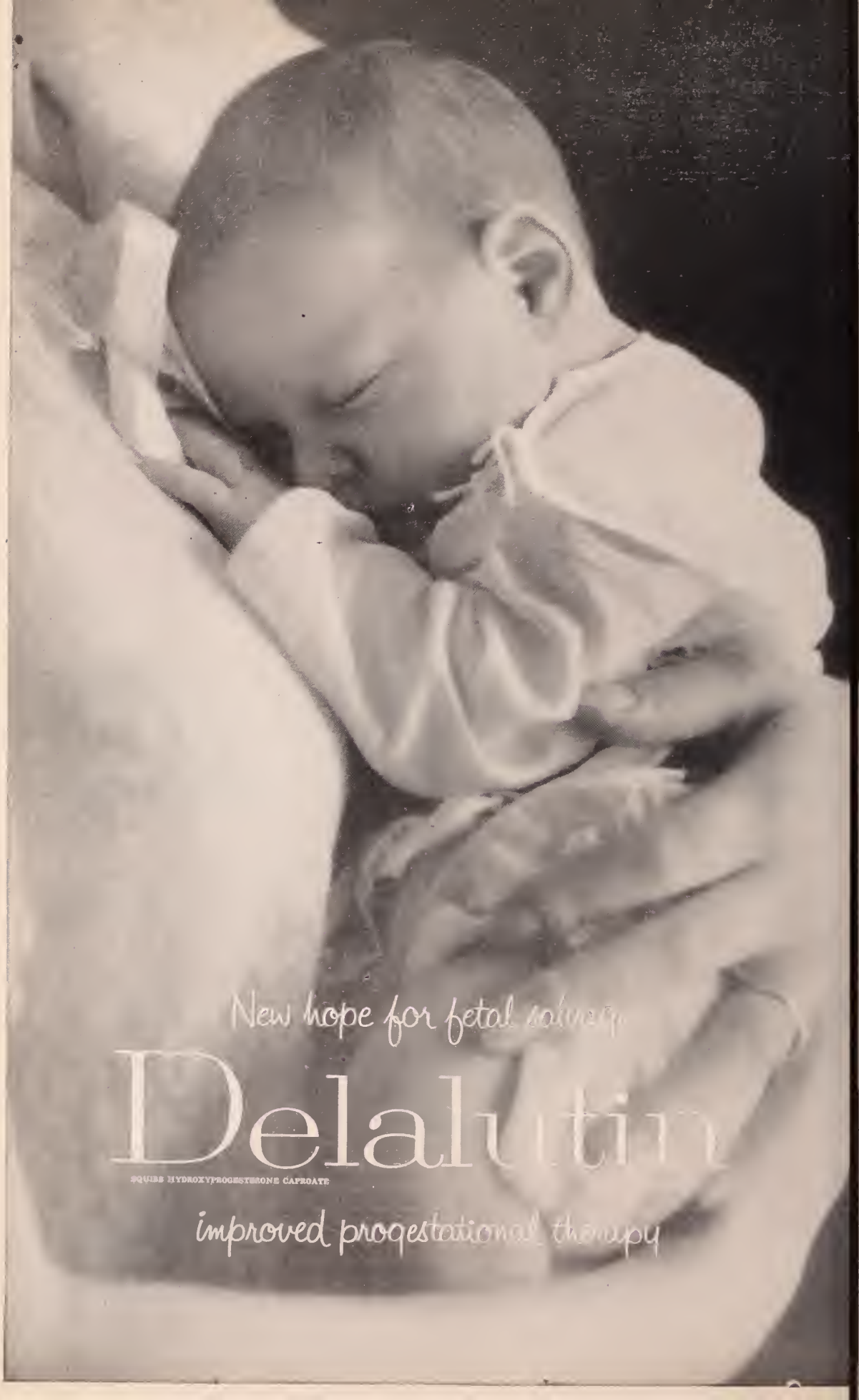
Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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greater antihypertensive effect...fewer side effects

HYDROPRES*

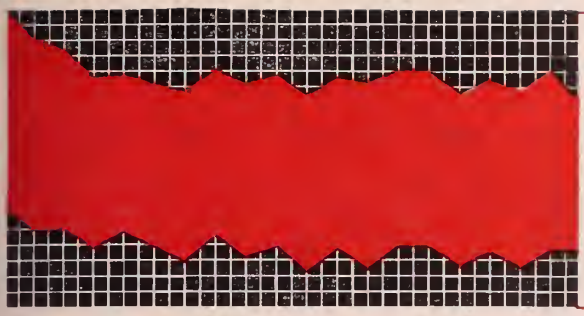
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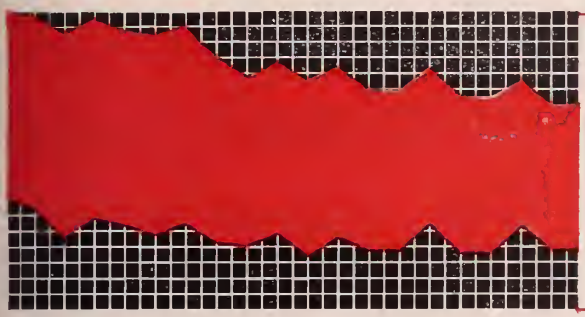
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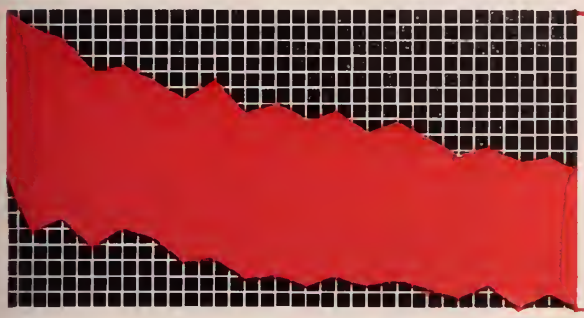
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HYDRODIURIL alone



RESERPINE alone



HYDROPRES
much more effective
than either of its
components alone

- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25
25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

HYDROPRES-50
50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

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"During the initial week of therapy, when the dose of nitrofurantoin was 100 mg. four times a day, the urine became free of pus and bacteria. Symptoms of urinary frequency, urgency, and dysuria were relieved."[2]

FREEDOM FROM DRUG-INDUCED COMPLICATIONS

- No significant development of bacterial resistance in over 7 years.
- No irreversible toxic effects on kidneys, liver, blood-forming organs or central nervous system ever reported.
- No monilial superinfection or staphylococcic enteritis ever reported.
- No fatalities from FURADANTIN therapy; the margin of safety is 90 to 1.
- "The drug was given continuously and safely for as long as three years."[2]

AVERAGE FURADANTIN ADULT DOSAGE: One 100 mg. tablet q.i.d. taken with meals and at bedtime with food or milk. Available as Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Stewart, B. L., and Rowe, H. J.: J. Am. M. Ass. 160:1221, 1956. 2. Lippman, R. W., et al.: J. Urol., Balt. 80:77, 1958.

NITROFURANS—a *unique* class of antimicrobials—neither antibiotics nor sulfonamides

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NOW—YOU CAN PRESCRIBE THE UNSURPASSED ADVANTAGE

superior antiallergic efficacy
with new *low dosage*

NEW

Aris

- combines the **anti-inflammatory, antiallergic** and **antihistaminic** effects of two agents—ARISTOCORT and chlorpheniramine which, separately, have been proved highly effective in the treatment of allergy
- permits **greater latitude** in adjusting dosage to minimum level needed for maintenance, because ARISTOCORT and chlorpheniramine are supplied in the **lowest dose tablets available** for each component alone
- supplies **ascorbic acid** for increased demand in stress conditions

Indications: *Generalized pruritus of allergic origin; hay fever, allergic rhinitis, perennial asthma, seasonal and perennial rhinitis, vasomotor rhinitis; drug reactions and other allergic conditions.*

Dosage: *One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.*

Precautions: *Drowsiness may occur, and is usually due to the antihistamine effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with* ARISTOMIN *have been relatively infrequent and minor in nature. However, since* ARISTOCORT *Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to corticosteroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.*

Further information available on request.

Supply: *Each* ARISTOMIN *Capsule contains:*

ARISTOCORT® *Triamcinolone*	*1 mg.*
Chlorpheniramine Maleate	*2 mg.*
Ascorbic Acid	*75 mg.*

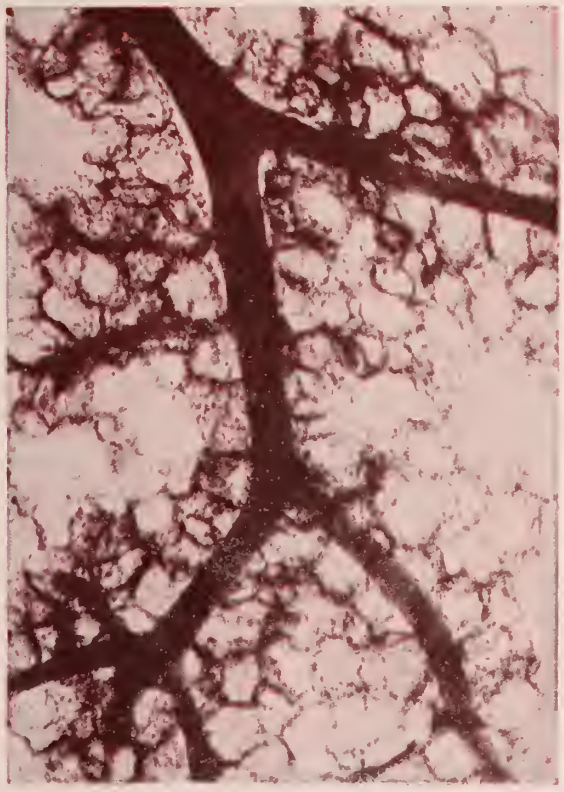
Bottles of 30 and 100

References: *1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.*

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Steroid-Antihistamine Compound LEDERLE



(lung x 65, injected with carbon-gelatin)

comments by clinical investigators:

"I would conclude that ARISTOMIN *is truly a worthwhile aid in treating allergic problems."*[1]

"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."[2]

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6 months to 2 years . . . . 1.5 to 2 cc.	
2 to 6 years . . 3 cc.	
adults and children over 6 . . . . . 1 tsp. (5 cc.)	

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

If Engineers were Plastic Surgeons

An engineer we know was gloomily looking at a mass of people. He thought that, from an engineering standpoint, the human body was poorly constructed. If the good Lord had entrusted the designing of the human body to him, he would really have produced a much more efficient machine for living. He thought it ridiculous that we could hear sounds in back of us but we could not see in back of us. To remedy this, if he were designing the human body, he would have a little periscope or tower arrangement on top of the head so that the eye could revolve a complete 360 degrees and see in front as well as in back. He would put an additional eye at the end of the index finger so a person could look into drawers and dark recesses. Indeed, he saw no reason why he would not provide this finger eye with a lighting apparatus so that it could illuminate dark spots.

Having once suffered from a slipped disc, he had strong ideas about the reconstruction of the human spine. He suggested that there should be two spinal columns, one coming up from the left thigh and the other from the right and that these should consist of separate discs. This, he pointed out, would give better support as well as greater flexibility.

He thought that our method of reproduction could also be improved—by which he meant only the way the baby came out of the uterus. The pelvic diameter should be made wide enough to accommodate even the largest baby's head—thus markedly reducing the risks of childbirth. He also thought that the system of having babies born head first was dreadfully inefficient. In his brave new world, the baby would come out feet first, being so designed that it would make little steps of its own to get out of the new and roomier uterus. In that situation, the patter of little feet would have a different meaning.

Our friend thought that it was silly to have the brain in its present, exposed position. The head is a natural target for all kinds of injuries. If the brain is as important as some people think it is, then it should be better protected. For this purpose the brain could be placed behind a cage of protective bones, or a plastic shell, in the chest, or if we let him

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design a set of ribs for the abdomen, the brain might logically be placed there.

He realized the value of a thoracic cage to protect our heart and lungs, but he thought that it might be done better with a plastic covering somewhat like the hood of an automobile engine. This sheathing would stretch all the way down to the thighs so that it would protect the abdominal organs as well. Our engineer friend could not understand why the important and susceptible abdominal organs are completely exposed while the lungs are protected by a barricade of ribs. It is a pity that our sense of smell has atrophied. He suggested that if the right index finger carried an eye, the left index finger might carry olfactory organs so that many places and people could be identified by extending the smelling finger.

The feet, he thought, should be broad, flat, and have suction cups rather than toes or toe nails. He admitted that the resulting picture might look like a monstrosity to most of us. On the other hand he points out that beauty is what you get used to, and after a couple of generations of the new design, it might be that we would like it better.

He conceded that the human heart was a model of engineering—a pump that functioned more than once a second, 24 hours a day, 365 days a year for 60 or 70 or 80 years without ever being refueled, lubricated or given a rest. He wondered though, why we shouldn't have an accessory pump to give the number 1 pump a rest now and then or to permit it to be removed for repairs. If the main function of the heart were to push the arterial blood onward, why couldn't this be accomplished by valves or by rubbery nodes on the arteries? Then we could have a heartless being.

He felt that the present system of breaking into the body for surgical repair was outmoded. Automobiles and elevators and other machines had access hatches. He liked the automobile where you could lift the hood by opening a pair of jaws. He visualized some such arrangement with the human body. As an alternate suggestion, he thought that the body could have a zipper on the side so that the surgeon could merely zip open the chest or abdomen any time he wanted to do a little repair job. It could be—but one wonders what the pinup girls would look like in that generation.

Geriatrics and Blue Shield

In 1951, among a total Blue Shield enrollment of 21 million persons, nearly a million (less than 5 per cent) were over 65 years of age. Six years later, in 1957, among the total of 40 million persons enrolled, 2½ million (or 6½ per cent) were over age 65. Thus, in six years, the number of Blue Shield members over 65 increased 170 per cent, while total Blue Shield enrollment increased only 85 per cent.

Of the total number of people past 65 who have medical-surgical insurance protection, about two-thirds are covered by Blue Shield.

Of all the people in the U. S., about 15 million are over 65 years old, and are *not* cared for by an established institution or agency. This represents 8 per cent of the total population. Blue Shield's ratio thus closely approximates the ratio of the total population in that group.

Blue Shield has always sought to serve medicine's inescapable responsibility to the *whole* community. It was until recently almost an exclusive Blue Shield feature that any member on retirement, or on leaving an insured group, could retain his coverage by "conversion" to a "direct-pay" basis. Few Plans impose any age limits on initial group enrollment, and an increasing number of Plans are accepting non-group members regardless of age.

Blue Shield is aware of medicine's responsibility to our senior citizens, and is prepared to follow the guidance and leadership of the profession in helping it meet this challenge.

Trustees' Meetings

April 12, 1959

The Trustees met on Sunday morning, April 12, 1959. The following actions were taken:

The State Department of Health has requested approval of a survey to determine the status of poliomyelitis immunization in population groups centered in areas of known low socio-economic level. The Medical Society has been asked to inform its component societies that it approves the survey, and to solicit cooperation at local level.

On the basis of the information supplied by the State Department of Health concerning the character and scope of the survey, the Executive Committee voted to approve the request. This action was approved by the Board.

The Board had named the A.M.A. Delegates as a special committee to review the Larson report of the A.M.A. Commission on Medical Care Plans, and to suggest the position of The Medical Society of New Jersey with reference to free choice of physician and group panel systems.

The Executive Committee voted to adopt the following report of the A.M.A. delegation, and directed that it be transmitted to the A.M.A. for the information of the A.M.A. House of Delegates:

> After careful consideration and study of the Report of the Commission on Medical Care Plans, the members of the New Jersey A.M.A. delegation are of the opinion that:
>
> 1. The basic concern of American medicine should be to render competent and adequate medical care.
>
> 2. The free choice of physician is a primary right of the American public and should receive continued support.
>
> 3. However, we are not unmindful of the fact that good and adequate medical care has been, and is being, rendered under conditions where free choice of physicians does not exist.
>
> 4. Where the free choice of physicians does not exist, the selection of physicians to render medical care should be based solely upon considerations of competency and ethical conformity.
>
> 5. In view of the socio-economic conditions today, it is our feeling that every physician has the right to dispose of his services as he sees fit, provided that in doing so he adheres to the Principles of Medical Ethics of the American Medical Association.

The above statement was approved. Also approved was the report of the Welfare Committee dated March 8, 1959 and published on page 367 of this JOURNAL.

Inter-Professional Code—The Board received and noted a communication advising that the Inter-Professional Code for Physicians and Attorneys was adopted on March 10, 1959, by the Bergen County Medical Society.

The New Jersey Division of Workmen's Compensation is circulating accident report forms which require physicians to supply details of diagnosis for transmission to injured employees and others.

The Board noted the legislation introduced in 1958 (A-189), to require use of such forms, failed of passage. Identical legislation has been introduced this year (A-260). These bills were *disapproved* by the Society because under many circumstances such reports would "require duplication of effort" and would be "disadvantageous to the welfare of the patient." Commercial insurance carriers oppose the use of such forms, and the N. J. Manufacturers Association is collecting affidavits from physicians opposing the use of such forms.

The Board expressed the opinion that physicians requested to sign the affidavit should cooperate with the Manufacturers Association by doing so.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that reaffirmation be made of the Board's position taken November 16, 1958 ". . . that the Society is opposed to such a regulation because no one individual or agency should be permitted to interfere between the doctor and the patient. Nothing should interfere with the personal doctor-patient relationship."

H. R. 4184 calls for the construction of a new Veterans Administration hospital in southern New Jersey. Upon motion by Dr. Sharp—seconded by Dr. Kaufman, and carried—it directed that component societies in southern New Jersey be informed of this bill and of the proposed construction, to the end that they may determine whether or not, in their view, these added facilities are necessary or desirable.

Chairman of the Special Committee on the Conservation of Vision, Dr. Jaeckle, reported

on the Board's referral of the request of a union representative for the Society's cooperation in setting up a pre-financed medical eye care program for union members through union welfare funds.

The report outlined the committee's discussion with the union representative and the conclusions of the committee arrived at in executive session. The committee submitted two recommendations:

1. That the Board of Trustees approve in principle the development of an ophthalmologic plan to make available the services of diagnostic examination (including refraction) and initial treatment (including the prescription and provision of glasses) by physicians to members of unions interested on a funded, pre-financed basis.

Upon motion by Dr. Greifinger—seconded by Dr. Buchanan, and carried; Dr. Allman dissenting—the recommendation was approved.

2. That the Special Committee on the Conservation of Vision be authorized to develop a plan for a pilot project and report to the Board of Trustees.

Upon motion by Dr. Bowers—seconded by Dr. McCall, and carried—the recommendation was approved.

April 24, 1959

At its meeting on April 24, the Board considered a request from U. S. Senator Humphrey, Chairman of the Senate Subcommittee on International Organizations, for the Society's cooperation in an international health study. Specific request was made that the Society name some leading New Jersey physicians who could provide expert judgment on the following question:

"What should the United States Government do to strengthen international collaboration toward the conquest of major killing and crippling diseases—such as cancer, cardiovascular ailments, neurological, mental disorders and the like?"

The chairman called for nominations and, upon motion, a number of names were suggested. The Board approved the names submitted, and instructed that full descriptions be included in the reply to Senator Humphrey.

LIABILITY INSURANCE FOR EMPLOYED PHYSICIANS

Dr. Hurtt brought to the Board a problem arising from the fact that physicians employed in state, county, and municipal institutions are not protected by liability insurance, because their personal liability coverage does not include their acts as institutional employees. It is the suggestion of the Committee on Medical Defense and Insurance that governmental employed M.D.'s be warned that their personal liability coverage does not protect them in their official acts as such employees and that they should be sure they are covered in both capacities. Further details will be found on page 370 of this JOURNAL.

It was agreed that a letter of warning be sent to the presidents of all hospital medical staffs in New Jersey, presidents of all component societies, administrators of all New Jersey hospitals, and to the New Jersey Hospital Association; and that a warning notice be published in THE JOURNAL and in the Membership *News Letter*.

COMPENSATION FEES

Report was made of a letter received by the State Department of Law and Public Safety, by a physician who protested the adoption of the Medical-Surgical Plan's fee schedule in payment of compensations claims involving state employees.

Dr. Greifinger called attention to the fact that any employer, or carrier, or the State of New Jersey, acting as a corporation, has the right under the law to select physicians to treat injured employees. However, the State Bureau waives that right by allowing free choice of physician to the injured employee, and since the fees are paid from tax funds they must be uniform fees. Consequently the Bureau has selected the MSP fee schedule as a unilateral basis for payment.

Dr. Greifinger stressed that even though the MSP schedule may be considered fair, the rates should be established by agreement between the Bureau and the Medical Society. He repeated his recommendation that a committee be appointed to meet with representatives of the Claims Bureau, Department of Law and Public Safety, to come to some agreement as to the method and rate of payment for injured state employees in compensation cases.

April 28, 1959

At its reorganization meeting on April 28, 1959, the Trustees elected Dr. Luke A. Mulligan chairman and Dr. Jerome Kaufman sec-

retary of the Board. The Trustees voted to re-engage all salaried personnel of the Society in accordance with the personnel policy adopted at the February 1959 session of the Board. Dr. Buchanan was named as Alternate AMA Delegate to substitute for Dr. Blaisdell who will be unable to attend the 1959 AMA session. Doctors Lance and Diskan were named as alternate AMA delegates if other regularly selected delegates could not attend. A Special Committee to Study Liability Insurance was approved. Dr. M. H. Greifinger will be chairman and Dr. David B. Allman will be Advisor to this committee. Other members will be Doctors J. G. Kaufman, D. F. Featherston, Elton W. Lance and J. P. Donnelly.

It was agreed that the New Jersey delegates to the American Medical Association must be instructed in the matter of inclusion of physicians under Social Security, in view of the affirmative action taken by the House of Delegates.

On "Health Care of the Aged" it was voted that the Trustees of Medical-Surgical Plan of New Jersey be requested to call a special meeting to answer some of the objections raised by the House of Delegates, particularly as regards the increase in premium for this group.

It was agreed that the next meeting of the Board of Trustees would be held on May 17, 1959, that the item "Health Care of the Aged" would be the first order of business, and that the AMA delegates and alternates who will attend the June meeting in Atlantic City will be invited and urged to attend so that they may receive proper instructions as to the official position of the Society on the matter.

Dr. Allman moved—seconded by Dr. Bowers, and carried—that the President be requested to assign one or more members of the Board to each reference committee; and that these Trustees attend the meetings of their assigned reference committee to set forth the attitude and opinions of the Trustees on matters to be considered by the reference committee.

Welfare Committee

The following actions of the March 8, 1959, Welfare Committee meeting were approved by the Board of Trustees on April 12, 1959.

CANCER CONTROL

The rehabilitation program for cancer patients in New Jersey, proposed by the Medical and Executive Committee of the American Cancer Society, New Jersey Division — detailed as Part VII, Cancer Program in New Jersey—was approved for publication as an article in THE JOURNAL.

PUBLIC RELATIONS

With the issuance of the 1958-59 series of *Junior Health Hints* the subcommittee has completed its four-year series. It was unanimously agreed that next year (1959-60) Series One of the *Junior Health Hints* should be re-issued, and the whole cycle subsequently be repeated, with revisions as necessary. At the time of the distribution of the 1959-60 series, a questionnaire should be circulated soliciting replies concerning the practical worth of the series to users of *Junior Health Hints* and the desirability of the subcommittee's preparing and issuing a supplementary compilation presenting "the story of the conquest of disease."

The publicity attendant upon the 1958 Eye Health Screening Program was even more effective this year than in 1957. The subcommittee received the following report of the 1958 results with commendation: 160 newspaper articles, including 5 editorials and 6 pictures.

SUBCOMMITTEE ON PUBLIC HEALTH

The Special Committee on Conservation of Vision called attention to the practice of the Telephone Company of including the listing "Contact Lenses," in the classified directory, followed by the words "See Optometrists," thereby conveying the idea that contact lenses are something peculiar to optometry, and directing the public away from medical care, to the detriment of the patient. The Medical Society of New Jersey is asked to request all telephone companies in New Jersey to discontinue the listing of "Contact Lenses."

It is recommended that the Special Committee on Conservation of Vision prepare a series of informative articles for the guidance of physicians on the status of optometry and the A.M.A. position in regard to optometry.

Due to repeated amendments to the Optometry Act, the special committee offered the following recommendation for study and evaluation of the enlarged legal privileges of optometrists: that a thorough and comparative study of the Optometric Act in relation to the Medical Practice Act be made by the Special Committee on Conservation of Vision and the Subcommittee on Medical Practice, and that the committees be authorized to confer with the Society's legal counsel.

The special committee, as a result of the 1958 Eye Health Screening Program conducted last September, felt the free services by physicians to the public should be publicized, and submitted the following recommendation:

That the Society consider authorizing the Subcommittee on Public Relations to assemble information on the services contributed to the public by physicians in clinics in New Jersey and to publish the information as a public relations project.

The Special Committee on Mental Health requested that The Medical Society of New Jersey be apprised of the fact that the New Jersey Neuro-Psychiatric Association—concerned as to the effect on the mental health of the people of New Jersey resulting from non-medical personnel treating mental illness unsupervised—have attempted to evolve a plan for legislation to control this practice in cooperation with the related professions of psychologists and social workers, but have been unsuccessful.

The special committee offered a recommendation regarding epileptics, with special reference to their obtaining drivers' licenses, and suggested the matter be taken up with the Commissioner of Motor Vehicles. The Society's Special Committee on Traffic Safety has established liaison with the Motor Vehicle Division. Means to revoke licenses of epileptics presently driving should be evolved. The following recommendation was approved.

That the following matters be brought to the attention of the Special Committee on Traffic Safety:

(1) Any epileptic who has been seizure free, with or without medication, for a period of two years should be given the right to a driver's license from the standpoint of his epilepsy.

(2) Some method should be devised to suspend the licenses of known epileptics presently driving, until the requirements of (1) above are met.

The Special Committee on Chronically Ill and Aging approves in principle the proposed movement of the State Division of Constructive Health to initiate services for mentally retarded children in specific locations by utilization of general hospitals. However, the special committee is of the opinion that implementation of the plan raises many questions as to the roles of the hospitals and the physicians. It is recommended that the Medical Society's liaison representative with the State Department of Health be communicated with in regard to this program.

The special committee is receiving inquiries regarding facilities for the aging in New Jersey. It is the special committee's opinion that the collecting and supplying of such information should be under medical leadership at local level.

Recommendation: That county chairmen of committees on chronically ill and aging be requested to consider the establishment of an information and referral center in each county, to cooperate in the development of facilities and information and referral centers for the chronically ill and aging.

The special committee recommended that steps be taken to secure representation from The Medical Society of New Jersey in the Division for Aging of the State Department of Health. It is also recommended that the Medical Society have the periodical "American Medical Association Planning Conference on Medical and Social Action in the Field of Aging" sent to county chairmen of committees on the chronically ill.

The special committee discussed the high price of some drugs and the inability of the aged to pay for them. It was felt that the American Medical Association should be requested to consider the problem of the high cost of drugs for the indigent and medically indigent—the objective being to discover means to make these drugs available to these patients at a lower than usual retail cost upon the recommendation of their physicians. They ask that this request be sent to the American Medical Association.

LEGISLATION

S-57 Cowgill, Stout—To define pharmacy as a profession and to forbid dispensing and retailing by unlicensed persons of certain defined drugs and medicines. *Approved with proviso* . . . that lines 35, 36, 37 (g) be amended to read: ". . . or notice limiting dosage or use;"

The subcommittee agreed that the defects in last year's version of this bill (S-64) have in large part

been eliminated in the current measure. The only remaining dissatisfaction centered about section (g) of that portion of the bill listing the drugs or medicines which may be sold only by a registered pharmacist. Section (g)—page 3, lines 35-37—now reads: "or to any drug or medicine which bears a label containing any warning, caution, or notice as to limited use or directions for keeping or storage;"

The subcommittee agreed that if this were amended to read: ". . . or notice limiting dosage or use;" it would recommend that the bill be then approved.

S-60 Hannold, Waddington—To extend until June 30, 1960 the time within which municipalities may require that all garbage shall be disposed of by sanitary land-fill or incinerator method.

Disapproved . . . because present requirements under current ordinance are more in the interests of the public health.

S-71 Waddington—To require as a condition precedent to a person's obtaining a motor vehicle license that such applicant consent to take breath or blood tests in suspected drunken driving cases. *Approved.*

S-74 Dumont—To define the term "patent and proprietary medicine" under the Pharmacy Act. *Disapproved* . . . because the subcommittee is of the opinion that section 2 of this bill empowers the manufacturer to determine what is non-poisonous, because this section declares: ". . . the term 'non-poisonous' shall mean and include those preparations which are not dangerous to health when used in the dosage, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof." It is unwise and undesirable and contrary to the public interest, that the manufacturer be the sole arbiter of what is "non-poisonous." Furthermore, The Medical Society of New Jersey looks with disfavor on any legislation which would relax the salutary controls necessary for the protection of the public and which would tend to encourage self-medication on the part of the public.

A-125 Beadleston—To provide for special educational services for emotionally and socially maladjusted pupils. *Disapproved* . . . because it involves a dangerous and undesirable delegation of broad powers and responsibilities.

A-168 Musto, Hauser, Kurtz, Matthews—Companion bill to S-71. *Approved.*

A-178 Kijewski, Musto, Salsburg—To regulate and license establishments used in the pursuit of ophthalmic dispensing. *Approved.*

A-181 Hauser, Musto, Bivona—To allow any legally incorporated humane society to enforce certain of the provisions of the laws relating to cruelty to animals. *Disapproved* . . . because existing laws which delegate this power to the New Jersey SPCA are adequate.

A-194 Brown—To provide for voluntary deduction from public employee pensions for Blue Cross and Blue Shield insurance premiums. *No action.*

A-203 Meloni, Kay—To permit voluntary deductions from salaries of employees of counties, municipalities, and school districts for payment of group life, health, and accident insurance; hospital service and medical and surgical insurance. *No action.*

A-224 Kay—To extend the time when municipalities may require that trash and garbage be disposed of by land-fill or incineration method. *Disapproved* . . . because present requirements under current ordinance are more in the interests of the public health.

A-244 Stewart, Panaro, Farrington—To provide certain hospital, medical, and surgical benefits to state employees with costs to be borne by the State. *Approved with proviso* . . . that the phrase "in any non-profit service and medical service plan" be reworded to read "in any private incorporated hospital service and medical service plan."

A-251 Miller—To require footprints of newborn babies. *Action deferred* . . . pending further information from sponsor.

A-308 Meloni, Flynn, Werner, Miller, Kijewski, McGowan, Lynch—To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approved.* (vote of 7 to 2—Doctors Hollingsworth and Madara dissenting).

A-415 Musto, Kijewski, Sabello—To include chiropractors' services within the purview of the Workmen's Compensation Act. *Disapproved* . . . because it would involve extension of the scope of the practice of chiropractic.

A-448 Lynch, Flynn, Miller, McGowan, Werner—To remove ophthalmic technicians from the provision of the Ophthalmic Act. *Disapproved* . . . because it would weaken the present law and impair the protection presently afforded without accomplishing any appreciable substitute benefit.

A-260 Meloni—To amend the Workmen's Compensation Act to provide that an injured employee shall be supplied with reports from the treating doctor and hospital. *Disapproved* . . . because such a requirement would involve a duplication of effort and, in some instances, would be disadvantageous to the welfare of the patient.

A-265 Kesselhaut—To provide for the reg-

istration and licensing of electrologists by the Board of Medical Examiners. *Action deferred* . . . pending report from American Medical Association.

AJR-1 *Weber*—To declare the month of April as "Cancer Control Month." *Approved.*

AJR-5 *Meloni*—To advise the Hospital Service Plan of New Jersey and the Medical-Surgical Plan of New Jersey that it is the desire of the Legislature that they make available hospitalization and surgical plans to persons over sixty-five, whether retired or not, at a premium reduced by one-half of the premium regularly charged for such coverage. *No action.*

AJR-8 *Franklin, Maraziti, Williams*—To reconstitute the commission created to study the administration of public medical care in various levels of government for the recipients of public assistance who are residents of the State, or those residents not requiring public assistance, but unable to finance medical care. *Approved.*

ACR-6 *Hughes*—To reconstitute the legislative commission to study the operation and effect upon the health and welfare of the people by the proposed new mass advertising medium known as "subliminal projection" or "hidden message advertising." *No action.*

ACR-11 *Franklin, Maraziti, Bivona, Williams*—To reconstitute the Commission on Mental Health. *Approved.*

SUBCOMMITTEE ON MEDICAL PRACTICE

The subcommittee reports progress on the establishment of a New Jersey Relative Value Schedule as a standard for evaluating professional services. At a meeting of the subcommittee with representatives from 17 New Jersey specialty societies, the joint group was in agreement that a Relative Value Schedule has merit, and that the Subcommittee on Medical Practice should proceed toward the development of such a schedule for New Jersey. The representatives of the specialty societies requested that, when a Relative Value Schedule is established, they be permitted to work up the individual unit values for services in their specialties. The specialty societies have been requested to submit their individual unit values and, with the approval of the Board of Trustees, the subcommittee is working toward the establishment of a Relative Value Schedule for New Jersey.

Liability Insurance for Institutional Physicians

Physicians employed in or by state, county, or municipal institutions are not protected by liability insurance. Personal liability coverage does *not* include their acts as institutional employees. It is the suggestion of the Committee on Medical Defense and Insurance that governmental employed M.D.'s be warned that their personal liability coverage does *not* protect them in their official acts as such employees. They should be sure they are covered in both capacities.

Legal counsel reported he had reviewed the committee's material on the matter. A recent decision (April 17, 1959), in the case of *Steiner v. Gordon*, held that a physician is not personally liable for acts performed in his official capacity as superintendent of a state or county hospital. It might be assumed that a similar opinion would obtain for physicians in any level or division of governmental service. However, counsel emphasized, this ruling does *not apply to physicians employed by private institutions.* The statute interpreted says the State employed physicians shall have immunity for an official act. There may be concern that this decision might be upset by the Supreme Court, but it is doubtful that this will happen. It is a point, however, that the committee should consider.

It was decided that our Board of Trustees go on record as recommending to physicians and administrators in private and public institutions, that they have sufficient insurance coverage and protection. The Board also decided that a letter of warning be sent to the presidents of all hospital medical staffs in New Jersey, presidents of all component societies, administrators of all New Jersey hospitals, and to the New Jersey Hospital Association; and that a warning notice be published in THE JOURNAL and in the Membership *News Letter.*

Retirement of Dr. Tarbell

For a half-century Dr. H. A. Tarbell has been Treasurer of the Society for the Relief of Widows and Orphans of Medical Men. At the wonderful age of 81, Dr. Tarbell has decided to retire from those duties. This retirement rouses many nostalgic memories in oldtimers. Dr. Tarbell was born in 1878—Rutherford B. Hayes was President of the United States then. Truman, Roosevelt and Eisenhower had not even been born. The Civil War was only a decade away and many people then living had seen Abraham Lincoln. Custer's last stand had been made only 2 years before. Newark was a pleasant, if somewhat overgrown, village on the Passaic. The Tarbell family home just east of Lincoln Park was in one of Newark's loveliest residential districts. In 1900 he was graduated from the medical school of Yale University.

Here he is—81 years old and going strong. What a period of history it has been! When Harold Tarbell was 4 years old, Koch isolated the tubercle bacillus; when he was 7, Pasteur developed rabies inoculation. He was 12 years old when diphtheria antitoxin was first produced. At the age of 16 he saw Coxey's army tramp on to Washington. Just one year later, Roentgen discovered x-rays. He was 20 when the Spanish-American War started, and 23 when Adrenalin was first isolated. He saw the start of the Russo-Japanese War at age 26 and was 28 when Thaw killed White. That same year—1906—saw Wassermann's report of his test, and the development by Binet and Simon of the modern I. Q. form. Harold Tarbell was 35 when the Shick test was announced and 44 when insulin was isolated. He was 49 years old when Lindbergh made his first flight and 51 when penicillin was discovered.

Through it all he remained the good physician, the carrier of our noblest professional heritage. It was characteristic of him that he so long labored on behalf of others in the Society for the Relief of Widows and Orphans. The treasurer's books have been turned over to Dr. George F. Stoll of Belleville. But the Society will always be identified with Harold Tarbell. We all wish him many years of pleasant and well-earned retirement! He is a model for all of us.

Do You Know Any of These?

The State Board of Medical Examiners has submitted a list of persons about whom they need more information. A reader who has information about any of these is requested to communicate with the Secretary of the State Board of Medical Examiners at 28 West State Street, Trenton, New Jersey.

The list follows:

Edwin J. Benz—Haledon, N. J.
Voorhees G. Cheathem—Plainfield, N. J.
Mrs. William Decker—East Orange N. J.
Richard Furlong—Paterson, N. J.
Martin Kelty—Philadelphia, Pa.
Victoria Kleczkowska—Jersey City, N. J.
Albert Kreiger—Paterson, N. J.
Beverly R. McPhail—Maywood, N. J.
Jessie Mingo—Garfield, N. J.
Joseph F. Parker—Paterson, N. J.
Antonio Sansone—Newark, N. J.
Della Spinella—Jersey City, N. J.
Francesco Verdiglione—Camden, N. J.
Eugene B. Taylor—Cranford, N. J.
Abner H. West—Keyport, N. J.

New N. J. Diplomates in Ob-Gyn

The following New Jersey doctors were certified by the American Board of Obstetrics and Gynecology on May 16, 1959, when final certifications in this specialty were made:

Charles H. Bippart, Morristown
Elizabeth L. Coultas, Madison
Stanley J. Gusciora, Passaic
Richard W. Holeman, Fair Lawn
A. Starr Ingram, Westfield
John J. Litz, Haddonfield
Ralph J. Onofrio, Camden
Carmen A. Prunetti, Trenton
Christopher T. Reilly, Ridgewood
Donald K. Sass, Salem
Francis U. Seiler, Trenton
Werner Steinberg, Linden
Morris S. Weiss, Asbury Park

193rd Annual Meeting — April 25-29, 1959
Haddon Hall, Atlantic City

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigations, judged on the basis of originality and excellence of presentation:

First Place: Cardiac Valvular Dynamics

Julio C. Davila, M.D., Robert G. Trout, M.D., Robert P. Glover, M.D., Philip Custer, M.D., and Joseph Sunner, Presbyterian Hospital, Philadelphia, Pa.

Second Place: Aorto-iliopelvic Lymphadenectomy with Resection for Cancer of the Left Colon and Rectum—5-Year Survivals

Harry E. Bacon, M.D., Julius L. Berkley, M.D., Julio R. Pineda, M.D., and Burchard E. Winne, M.D., Temple University Medical Center, Philadelphia, Pa.

Honorable Mention: Electromyography—Classical, Present, and Future Uses

Earl F. Hoerner, M.D., New Jersey Orthopaedic Hospital, Orange

Class II—New Jersey Exhibitors:

First Place: Pathology of the G. U. Tract in Natural Color

Martin R. Rush, M.D., and Alfredo D. Zavaleta, M.D., Monmouth Medical Center, Long Branch

Second Place: The Non-operative Aspects of Pediatric Surgery

Richard C. Reed, M.D., and Celestino Clemente, M.D., Babies' Hospital Unit, United Hospitals of Newark

Honorable Mention: Maximal Reconstitution of the Mitral Valve

Charles P. Bailey, M.D., Dryden Morse, M.D., George D. Geckler, M.D., and Jacob Zimmerman, M.D., Bailey Thoracic Clinic, Philadelphia, Pa.

Official Attendance

County	Delegates	Members	Total
Atlantic	10	74	84
Bergen	41	42	83
Burlington	6	16	22
Camden	22	43	65
Cape May	3	5	8
Cumberland	6	14	20
Essex	82	155	237
Gloucester	4	11	15
Hudson	25	26	51
Hunterdon	3	1	4
Mercer	25	44	69
Middlesex	14	25	39
Monmouth	19	47	66
Morris	16	26	42
Ocean	2	14	16
Passaic	23	31	54
Salem	3	10	13
Somerset	6	7	13
Sussex	3	3	6
Union	34	43	77
Warren	2	4	6
Fellows, Officers, Trustees, Councilors	22	0	22
	371	641	1,012
Physician Guests			79
Physician Exhibitors			33
TOTAL PHYSICIAN REGISTRATION			1,124
Auxiliary Members			406
Visitors			265
Exhibitors			261
TOTAL REGISTRATION			2,056

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Totals
1959	1,124	932	2,056
1958	1,193	950	2,143
1957	1,202	909	2,111
1956	1,238	947	2,185
1955	1,040	790	1,830

Obituaries • • •

DR. EDWARD J. FISCHER

Born in New York in 1898, Dr. Edward J. Fischer died at his West Orange home on May 6. Dr. Fischer was an alumnus of Georgetown University Medical School, class of 1922. After doing graduate work in Washington, he interned in Trenton and then came to West Orange, whose people he was then to serve for 35 years. He became an attending in medicine at St. Mary's Hospital in Orange. Active in civic affairs, he was senior examiner for the draft board during World War II, as well as police surgeon and West Orange Town Physician.

DR. ARTHUR J. GANLEY

One of East Orange's senior physicians, Dr. Arthur J. Ganley, died on May 8, 1959, at the age of 70. Born in Methuen, Massachusetts, he attended Tufts College of Medicine from which he was graduated in 1915. He interned at St. Luke's Hospital in Bedford, Massachusetts, until 1917 when he was commissioned in the Army Medical Corps. Two years later, on being mustered out of the Army, he came to Newark and went into general practice. Increasingly interested in surgery, he became affiliated with surgical services at both Presbyterian and St. James Hospitals. He was elected to the New Jersey Society of Surgeons. Dr. Ganley was active in the affairs of the Essex County Medical Society, having had several terms of service as member of its Council. In 1921, Dr. Ganley moved to East Orange.

DR. ABRAHAM GOLDSTEIN

Born in New York City in 1887, Dr. Abraham Goldstein of Lakewood died on May 27, at the Paul Kimball Hospital, where he was an emeritus consultant in medicine. A graduate of the old Long Island College of Medicine, class of 1911, Dr. Goldstein did graduate work in pediatrics and internal medicine at Gouverneur Hospital and St. Marks Dispensary in New York. In 1922 he settled in Lakewood and for three decades served the people of Ocean County as a family doctor. Dr. Goldstein served a term as president of the Ocean County Medical Society, and another as chief of staff of the Paul Kimball Hospital. On the occasion of his 30th anniversary of service to that hospital he was awarded a special plaque of honor.

DR. CADWELL B. KEENEY

A half a century of active medical practice came to a close on May 22 with the death on that day of Dr. Cadwell B. Keeney of Summit. Born in 1881, Dr. Keeney was graduated in 1907 from the medical school of Columbia University. In World War I he was on active duty in the medical corps of the Army. In World War II he was on the selective service board. He was a family doctor with a special interest in pediatrics in which he was something of a pioneer. He was affiliated with the Overlook Hospital in Summit and was an emeritus member of the Union County Medical Society. In 1957, Dr. Keeney received our State Society's Golden Merit Award.

DR. THOMAS S. McKINNEY

At the tragically early age of 40, Dr. Thomas S. McKinney died suddenly on May 4. He was assistant director of anesthesia at the Hackensack Hospital. Dr. McKinney received his baccalaureate degree at Rutgers, and his M.D. degree from the New York Medical College in 1944. After interning at the Hackensack Hospital, he accepted a residency appointment in anesthesiology in Hartford. He became a Diplomate of the American Board of Anesthesiology and a Fellow of the American College of Anesthesiology. He served in the Navy Medical Corps twice—once from 1943 through 1945 and again from 1952 to 1954. He was a member of the Bergen County Medical Society.

DR. GEORGE W. MUTTART

The oldest medical practitioner in Hudson County died on May 16 at the grand age of 92. He was Dr. George W. Muttart who was born in Canada in 1866 and was graduated from Bellevue in 1892. At first a general practitioner, he became increasingly interested in surgery and for many decades was affiliated with the surgical staffs of Greenville, Fairmount and Christ Hospitals in Jersey City. He was an emeritus member of the Hudson County Medical Society.

Announcements • • •

Symposium on Athletic Injuries

Mid-August is pleasant on the shores of Narraganset. You can combine a vacation with a symposium on athletic injuries at the University of Rhode Island, August 17 and 18. For program, write to Dr. A. A. Savastano at 205 Waterman Street, Providence 6, R.I.

Ultrasonics in Medicine

Ultrasonics—medicine's newest tool—will be described and evaluated in Minneapolis on September 2. This will be the theme of the annual American Institute of Ultrasonics. More details may be obtained from Dr. John H. Aldes at 4833 Fountain Avenue, Los Angeles 29, California.

International College of Surgeons

September 13 through 17 are the days for the next session of the North American Federation, FICS. All specialties of surgery have been programmed. This workshop will be at the Palmer House in Chicago. For details, write to the International College of Surgery at 1516 Lake Shore Drive, Chicago 10, Illinois.

Sports Medicine Congress

A Sports Medicine Congress will be held on the Chicago campus of Northwestern University September 1 and 2, and will feature experts in athletic training, care of injuries, diet, cardiovascular effects of sports activity, and other facets of sports medicine.

Paul Dudley White, M.D., will speak at the plenary session of the Congress September 1. On September 2, Allen J. Ryan, M.D., of Menden, Conn., will be the feature speaker.

The Congress will be open to all interested in the field of sports medicine. Further information can be obtained from Dr. T. R. Van Dellen at Pan American Games, Inc., 310 South Michigan Ave., Chicago 4.

Rhinological Society

On Saturday, October 10, there will be a full-day work-shop on diseases of the nose at the Belmont Hotel in Chicago. This is under sponsorship of the American Rhinological Society. Further details may be obtained from the American Rhinological Society at 530 West Hawthorne Place, Chicago 13, Illinois.

Cancer Symposium

October 26 and 27 (a Monday and a Tuesday) have been set aside for a symposium in New York on the early diagnosis of cancer. Sponsored by the American Cancer Society, the program is packed with papers on early diagnosis. A faculty of top cancer experts has been selected. For details, write to the American Cancer Society at 521 West 57 Street, New York 19, N. Y. The symposium will be at the Biltmore.

Urology Award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years; and to hospital interns and residents doing research in urology.

For particulars write the Executive Secretary, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1959.

NP Positions for Inexperienced MDs

The neurologic and psychiatric services of the V.A Hospital in East Orange, N. J. have a few vacancies for physicians. This is a modern teaching hospital. For details write to Director of Professional Services there.

County Society Reports • • •

Bergen

The annual election of the *Bergen County Medical Society* was held May 12.

George Heller, M.D., President, read a letter from Mrs. George O. Rowohlt in which she thanked the Society for the flowers presented to her by the President of this Society at the time of her inauguration as President of the Woman's Auxiliary to The Medical Society of New Jersey at its recent Annual Meeting in Atlantic City.

The following new Regular members were presented with their certificates of membership; Drs. A. F. Bonacarti, J. P. Lauricella, J. J. Speranza, George Zavitzianos and Murray Kahn.

The following named were elected to membership: Regular—Robert J. Widows, Irwin Glasner; Associate—Max Goldberg, and Harold Lakin.

The Secretary read a tribute to Dr. Thomas S. McKinney who died May 4. This was written by Dr. Leonard Brown and signed by a number of his colleagues on the medical staff of Hackensack Hospital.

The Secretary read the following slate of officers and members of the Judicial Committee which had been placed in nomination at the March 10 regular meeting: President—Donald B. Hull; First Vice-President—George O. Rowohlt; Second Vice-President—Walter Wahrenberger; Secretary and Reporter—Charles P. Campbell; Treasurer—John P. O'Connor; Assistant Treasurer—Alfred A. Alessi; Member Judicial Committee (Class 1964)—John E. McWhorter. The above named were elected.

The President turned the meeting over to Dr. Tor Richter, Chairman of the Program Committee. Dr. Richter introduced Dr. Lloyd Morrow of Passaic, President of the Society of Clinical Psychiatrists of Northern New Jersey, who informed the audience that the lecture to follow was the Donald V. Leddy Memorial Lecture jointly sponsored by the Bergen County Medical Society and the Society of Clinical Psychiatrists of Northern New Jersey. He spoke briefly of Dr. Leddy and his untimely death, cutting short a most promising medical career in psychiatry in Ridgewood. He expressed his appreciation as well as that of the Psychiatric Society for the privilege of holding the lecture in Dr. Leddy's memory at the annual meeting of the Bergen County Medical Society of which Dr. Leddy had been a member.

Dr. Richter then presented Dr. Bernard C. Meyer, Associate Attending Psychiatrist, Mount Sinai Hospital, New York City, who spoke on "Psychiatric Aspects of Surgical Practice." Dr. Meyer's intensely interesting discussion emphasized that the psychological preparation of a patient pre-operatively and psychiatric assistance post-operatively were very frequently most important adjuncts in obtaining optimum results from the surgery. The patient's proper frame of mind both pre- and post-operatively can often be as beneficial as the surgeon's technical skill. He enumerated many of the pre-operative psychological conditions and causes which could well indicate postponement of the surgery needed until corrected and presented many instances when the lack of recognition of post-operative depression militated against normal recovery of the patient.

At the conclusion of his talk, Dr. Richter thanked Dr. Meyer for his very "provocative presentation" and after several questions had been answered, the meeting was adjourned at 10:40 p.m.

CHARLES P. CAMPBELL, M.D.

Reporter

Cumberland

The June meeting of the *Cumberland County Medical Society* was held at Palatine Lake in the cabin of the Owens-Illinois Glass Co., at 2:30 p.m., June 2, with Dr. M. David Baxter, Immediate Past-President, presiding. Fifty members were present.

Drs. Frank Poracaro and Joseph Dortch of Vineland, having been approved by the Executive Committee for Associate membership, were introduced to the Society. It was announced that Charles Butcher, M.D., had been honored by The Medical Society of New Jersey as a Golden Merit Laureate for 50 years of outstanding service in the practice of medicine.

Dr. Butcher represents the fourth generation of his family to practice medicine in the Heislerville area since 1825. He was born in Heislerville and returned there to practice in 1911, after completing his training at the Jefferson Medical School (1909). Dr. Butcher has done further service as secretary of the Tuberculosis Association, past-president of the Rotarians, as well as past president of the county society.

Dr. Baxter introduced the new officers: Benjamin Berkowitz, M.D., of Bridgeton, *President;* Alfred O. Davies, M.D., Millville, *President-Elect;* Mary Bacon, M.D., Bridgeton, *Secretary;* Samuel B. Pole, III, M.D., Bridgeton, *Treasurer;* and Leonard G. Scott, M.D., Bridgeton, *Reporter.*

The meeting was adjourned and the guests partook of a most sumptuous display of the culinary art prepared by Mr. Herbert Hill and his staff.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on April 16. Dr. S. Thomas Camp, President, called the meeting to order.

Perry S. MacNeal, M.D., Physician to Pennsylvania Hospital, was the speaker. His topic: Office management of the patient with diabetes.

Communications were read and discussed regarding local and state considerations.

Dr. Campo urged writing our Senators regarding support of the Simpson-Keogh Bill.

Dr. Richard Gotchel—our newest member—was introduced and given a hearty welcome.

Membership in Gloucester County Medical Society: 71, plus 2 non-resident and 1 Emeritus member.

The meeting was adjourned at 11:45 p.m. Twenty-one members were present.

DOROTHY M. ROGERS, M.D.

Reporter

Mercer

Members of the Society of Mercer County Pharmacists, and residents and interns of local hospitals were the guests of the *Mercer County Component Medical Society* at its annual picnic, Wednesday afternoon, June 17, at the Trenton Country Club. Details were handled by Dr. George W. Irmisch, Chairman of the Entertainment Committee, with the assistance of Drs. William H. Coleman, Marvin Friedmann, and Peter J. Norton.

A moment of silent tribute to the memory of Dr. David B. Ackley was observed. Dr. Ackley, a past-president of the Society (1906), an emeritus member of the local and state medical societies, and the recipient of the Golden Merit Award in 1957, passed away Sunday, June 14.

During a short business session conducted by Dr. John A. Kinczel, President, the following physicians were elected to membership; Active—Dr. Siu-Won Chan; Dr. James B. Hastings (on transfer from Oswego (N.Y.) County Medical Society); Dr. Joseph L. Mooney, Jr.; and Dr. Guillermo J. Munoz. Associate—Dr. Nathaniel N. Boonin; Dr. Vito F. LaFranco; and Dr. Joseph F. McCarthy.

Prizes were awarded at the conclusion of the business session.

RALPH N. CAGAN, M.D.

Reporter

Middlesex

The regular meeting of the *Middlesex County Medical Society* was called to order by Dr. George J. Kohut, its president, at Roosevelt Hospital, Metuchen, May 20, at 9:00 p.m.

Drs. John G. Falcone, New Brunswick, Irwin Miller, Perth Amboy, and Balardino Lupini, Milltown, were elected to two years' Associate membership.

Dr. Calvin, Chairman of the 1959 Nominating Committee, presented the following panel of candidates:

President—John Albert Smith, M.D., South River

Vice-President—Stanley Gadek, M.D., Perth Amboy

Secretary—John S. Van Mater, M.D., New Brunswick

Treasurer—Reubin Levinson, M.D., Perth Amboy

Reporter—Thomas I. Steinberg, M.D., Metuchen

Board of Trustees—George J. Kohut, M.D., Chairman; Sidney D. Becker, M.D.; Charles H. Calvin, M.D.; Malcolm M. Dunham, M.D.; B. F. Slobodien, M.D.; Joseph F. Sandella, M.D.; Marshall Smith, M.D.; George Henderson, M.D. and Charles Gandek, M.D.

Judicial Medical Ethics Committee: (For 2 years) Benjamin F. Slobodien, M.D.; Eugene J. Tyrrell, M.D. and Ralph Siegel M.D.; (for one year)—S. David Miller, M.D. and W. E. Sherman, M.D.

Delegates and Alternates for three-year term:

Delegates—Sidney D. Becker, M.D.; Charles H. Calvin, M.D.; Malcolm M. Dunham, M.D.; Ralph Siegel, M.D.; Sol Gurshman, M.D.; Gerard R. Gessner, M.D.; Joseph F. Sandella, M.D. and A. Shayevitz, M.D.

Alternates—Cyril I. Hutner, M.D.; Louis A. Perillo, M.D.; Morton M. Klein, M.D.; Edward Brezinski, M.D.; Howard D. Slobodien, M.D.; Bartley M. Howley, M.D.; Alfred J. Barbano, M.D. and Harold B. Fein, M.D.

Delegate and Alternate to The State Nominating Committee—Charles H. Calvin, M.D. and Gerard R. Gessner, M.D.

Dr. William E. Sherman moved that the nominations be closed. This was passed unanimously and the candidates listed above were elected.

Dr. Howard B. Miller, Associate, Cytology Division, Post Graduate Hospital, New York, spoke on "Cytology—The Cellular Detection of Cancer." He stressed the criteria for determining cells to be malignant on Papanicolaou smears. Judging from the discussion and questions, this was one of the most enjoyable papers of the year.

DONALD T. AKEY, M.D.

Reporter

Passaic

The annual meeting of the *Passaic County Medical Society* was held May 19 at the Medical Society Building. The meeting was presided over by Dr. Theodore K. Graham, President.

Dr. Graham read a letter from the Bergen County County Medical Society and from the State So-

ciety on legislation S-147 which would accept the examination of the family physician in lieu of that of the school physician for school health records. This legislation was approved by the members.

Dr. Berkhout was then called upon to give further details on the mass immunization program. He requested the doctors to please send in their cards indicating their willingness to serve on the "Dollar Clinics," since this is a most worthy cause.

Dr. Graham read the report of the Nominating Committee as follows:

President—Julian Cohen, M.D.; First Vice-President—F. Albert Graeter, M.D.; Second Vice-President—David B. Levine, M.D.; Secretary—Joseph E. Mott, M.D.; Treasurer—Frank B. Vandebeek, M.D.; Ass't. Treasurer—M. Frank Kaletkowski, M.D.; Reporter—Irving Chrisman, M.D.; Board of Censors (3 years)—Theodore K. Graham, M.D.; (1 year—to fill unexpired term of Dr. Shulman)—Joseph R. Jehl, M.D.; Buildings Trustees (3 years) —John A. Ianacone, M.D.; Harry Wolfson, M.D.; Sandor A. Levinsohn, M.D.; William M. Sullivan, M.D.

The President called for nominations from the floor. There being no nominations, it was determined that the nominations be closed, a ballot cast, and the panel was unanimously elected.

Dr. Graham expressed his appreciation to the other officers of the society for their cooperation during the past year. He then introduced the new President, Dr. Julian Cohen, who thanked the members for the honor bestowed upon him.

Dr. Cohen then turned the meeting over to Dr. Samuel Deich who introduced the guest speaker, Judge Maurice A. Kaltz, Supervising Deputy, Director of Workmen's Compensation, State of New Jersey.

After a most interesting talk by Judge Kaltz, a collation was served.

DAVID B. LEVINE, M.D.

Reporter

Salem

The annual meeting and shad dinner of the *Salem County Medical Society* was held on Saturday, May 16, at the Salem Country Club. The retiring president, Dr. Charles E. Gilpatrick, commended the members of the Society for the assistance he had received during the past year. The following were elected to serve during 1959-60. Dr. George A. Nitshe, Jr.—President; Dr. Ford A. Spangler—Vice-President; Dr. Donald McLean—Treasurer; Dr. William L. Sprout—Secretary; and Dr. George F. Reichwein—Reporter.

Following an enjoyable dinner, Dr. Gilpatrick introduced Walter L. Lawrence and Fred L. Brown from the Public Relations Department of the RCA Victor Corporation in Camden. With the aid of sketches and recordings, they illustrated the beginnings of sound recording. The gradual evolution to the modern recording and sound equipment was most interesting to the audience.

Using the recently developed magnetic tape recording, the differences between high fidelity and stereophonic sound were illustrated. At this time a new medium of sound enjoyment is readily available which could not have been acquired for any price just ten years ago since it did not exist at that time. Of special interest at the close of the discussion were recordings of the voices of William Jennings Bryan and Woodrow Wilson. Besides the historical significance and value of these records they again served to illustrate the tremendous advances made in this medium of culture and entertainment in a relatively short span of years.

G. F. REICHWEIN, M.D.

Reporter

New Jersey Allergy Society

The *New Jersey Allergy Society* announces election of the following officers:

President—Frank L. Rosen, M.D., Newark
Vice-President—Joseph R. Jehl, M.D., Clifton
Secretary—Herbert W. Diefendorf, M.D., Summit
Treasurer—Francis A. Pflum, M.D., Asbury Park

Dr. Rosen is editor of the *Bulletin* of the Essex County Medical Society.

HERBERT W. DIEFENDORF, M.D.

Secretary

New Jersey Dermatological Society

The *New Jersey Dermatological Society* held its annual meeting on May 12. The following were installed as officers for 1959-1960:

President—John R. Tobey, M.D., Newark

First Vice-President—Eugene L. Miller, M.D., Newark

Second Vice-President—Samuel D. Kaplan, M.D., Elizabeth

Treasurer—Morton Kulick, M.D., Paterson

Recording Secretary—Max Braitman, M.D., West New York

Corresponding Secretary—Hugh McCulloch, Jr., M.D., North Plainfield

All inquiries and business should be addressed to the undersigned at 68 Watchung Ave., North Plainfield, N. J.

HUGH McCULLOCH, JR., M.D.

Corresponding Secretary

New Jersey Proctologic Society

The new officers elected at the annual meeting of the *New Jersey Proctologic Society* are as follows:

President—Lloyd B. Whitman, M.D., Bergenfield
Vice-President—Morando De Fronzo, M.D., Newark
Secretary—Henry T. Weiner, M.D., Perth Amboy
Treasurer—Sydney S. Pearl, M.D., Elizabeth

Guest speaker at the meeting was Dr. Charles Brown, Dean of Seton Hall College of Medicine and Dentistry, who gave an interesting talk on the curriculum and history of Seton Hall.

HENRY T. WEINER, M.D.

Secretary

Society for the Relief of Widows and Orphans

At the annual meeting of the *Society for the Relief of Widows and Orphans of Medical Men*, held at the home of its President, Dr. Earl LeRoy Wood, May 13, the following officers were re-elected for the ensuing year:

President—Earl LeRoy Wood, M.D.
Vice-President—Berthold T. D. Schwarz, M.D.
Secretary—Joseph W. Gardam, M.D.
Custodian—Herbert A. Schulte, M.D.
Treasurer—George F. Stoll, M.D.
Assistant Treasurer—James E. D. Gardam, M.D.
Trustees for three years: Ogden Carter, M.D., A. J. Gordon, M.D., Joseph R. Jehl, M.D.

The past-treasurer, Harold A. Tarbell, M.D., has retired at the age of 81 after serving the Society for 48 years, steadily and consistently in that post. His long service was recognized by the officers and trustees when he was presented with a beautiful clock suitably inscribed and calling attention to his years of devoted duty and effort. Dr. Stoll, his successor, is well known and is also a devoted person who will ably fill Dr. Tarbell's place.

Dr. William D. Miningham also retired as an active Trustee after many years of service as chairman of the Standing Committee. Dr. Joseph R. Jehl was elected to fill his place as Trustee for the next three years.

J. W. GARDAM, M.D.

Secretary

Book Reviews • • •

The Psychology of Medical Practice. By M. H. Hollender, M.D. Philadelphia 1958. Saunders. Pp. 276. ($6.50)

The four specialties of pediatrics, obstetrics, surgery and general medicine are here spotlighted in terms of doctor-patient relationships. Basically, the author's idea is that the doctor-patient relationship is too often viewed as a transaction in which the physician provides the patient with something. Dr. Hollender prefers to consider it an interpersonal phenomenon. The book abounds in practical advice on what to tell the patient and how to say it. There is an excellent and usable chapter on the psychology of the cancer patient. Dr. Julius Richmond has written two chapters on the pediatric patient which, by themselves, constitute a veritable textbook on orthopsychiatry. A chapter on the psychology of medication is probably unique in modern medical literature.

In a profession so weighted with texts on medical science, it is refreshing to find a volume which gives serious attention to the art of medicine.

HERBERT BOEHM, M.D.

Electrocardiography. By Michael Bernreiter, M.D. Philadelphia 1958. Lippincott. Pp. 134, with 92 illustrations. ($5.00)

There is, of course, no shortage of books on electrocardiography. However, there is enough new work in the field to warrant frequent revisions and occasional offerings of brand new works. This book is a new work, which has two sound features. One is the lucid style which makes the text readily understood by the non-cardiologist. The other is the author's willingness to consider the "why" of the tracings. It might be quicker in the short pull for the reader to memorize the ECG pattern in rote fashion. But in the long pull, this method is better. There is a good chapter on such basic electrical phenomena as depolarization and repolarization and the material on unipolar leads is up to the minute. The effect of drugs on the ECG tracings is also considered. The book is a sound *vade mecum* for the general practitioner or the medical specialist outside the field of internal medicine.

ULYSSES M. FRANK, M.D.

NOTE TO READERS

Before 1958, the Annual Reports were published prior to the Annual Meeting. The Transactions used to be issued as a supplement to THE JOURNAL in the fall. This year the annual reports and transactions are bound together in this issue of THE JOURNAL.

The action taken by the House of Delegates on each annual report is indicated in bold face type at the end of the report. The page numbers refer to the reference committee reports, which start on page 470.

The other activities of the annual meeting will be published periodically in THE JOURNAL and will be identified in the table of contents of each issue in which they appear, as well as in the index of the year.

INDEX

Accreditation of Hospitals and Intern and Resident Training Programs Resolution . 392
Aged, Health Care of . . . 386
Aged, Health Care of, Resolution . . . 455
American Medical Education Foundation 400, 401
Annual Meeting Committee . 408
Blood Bank Commission . 393
Blue Cross Inter-Plan Service Bank . 386
Budget . . . 401
Bylaws Revisions . . . 431
Cancer Control Committee . . 410
Child Health Committee . 420
Chiropodists, Medical-Surgical Plan Payment to 391
Chronically Ill and Aging Committee . . 421
Civil Defense-Disaster Control Committee . 425
Code for Physicians and Attorneys . . . 390
Conservation of Hearing and Speech Committee 422
Conservation of Vision Committee 422
Constitution and Bylaws Revision Committee 429
Constitutional Revisions . 430
Dues . . . 400, 401
Election . . . 479
Emeritus Membership Nominations 454
Executive Officer's Report 399
Finance and Budget Committee 400
Foreign Medical Schools Resolution 395
Honorary Membership Committee 401
Hospital Accreditation Resolution 392
Hospital Records, Examination of . 388
Hypnosis Resolution . 456
Impartial Medical Witnesses Resolution 390
Industrial Health Committee . 418
Intravenous Medication by Nurses 389
Judicial Council Report . . . 396
Legislation, Committee on . 413
Liability Countersuit 388
Maternal and Infant Welfare Committee 412
Medical Defense and Insurance Committee 403
Medical Education Committee 407
Medical-Legal Testimony 390
Medical Practice Committee 414
Medical Service Administration of New Jersey 459
Board of Governors Nominations 387
Budgetary Allotment for . 395
Budgetary Allotment for, Resolution . 455
Medicare Program . 460
Medical Student Loan Fund 386
Medical Student Loan Fund Committee . 426
Medical-Surgical Plan of New Jersey . . 463
Board of Trustees Nominations . . 387
Chiropodists, Payment to . . . 391
Contract Inequities . . . 391
Paid-up Policies in Blue Cross-Blue Shield Resolution . . . 456
X-Ray Diagnostic Services Resolution . . . 456
Medicare Program . . . 388, 460
Mental Health Committee . . . 423
Nominating Committee Report . . . 479
Nursing Homes for the Aged and Chronically Ill Resolution . . . 393
Optometrists and Drugs Resolution . . . 457
Optometrists—Contact Lenses and Drugs Resolution . . . 457
Optometrists, Voluntary Association between Physicians and, Resolution . . . 454
Paid-up Policies in Blue Cross-Blue Shield Resolution . . . 456
Physicians Placement Service . . . 427
Pre-School Inoculations and Vaccinations . . . 389
President's Address (Gardner) . . 480
President's Report . . . 380
Publication Committee . 402
Public Health Committee . 415
Public Relations Committee . . 416
Radiologic Hazards . . . 410
Reference Committees—
"A" . . . 470
"B" . . . 472
"C" . . . 473
"D" . . . 474
"E" . . . 475
Constitution and Bylaws . . . 478
Miscellaneous Business . 477
Resolutions and Memorials . 477
Rehabilitation Committee . . 424
Rehabilitation Services Directory Resolution 457
Resolutions (Indexed by Subject)
Retirement Plan for Physicians . . . 429
School Children, Tuberculosis Screening of . . . 394
Scientific Exhibit Committee . . . 408
Scientific Program Committee . . . 409
Secretary's Report . . . 382
Social Security for Physicians . 389
Social Security for Physicians Resolutions . 458
Technical Services by Non-professional Personnel . . . 390
Traffic Safety Committee . . . 428
Transactions, 1958, Approval . . . 478
Treasurer's Report . . . 383
Trustees' Report . . . 385
Tuberculosis Screening of School Children . . 394
Welfare Committee . . . 409
Woman's Auxiliary Advisory Committee . . . 407
Workmen's Compensation Committee . . . 419

Official Transactions of the House of Delegates

193rd ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J.

APRIL 25 - 29, 1959

ANNUAL REPORTS

President

(Reference Committee "A")

KENNETH E. GARDNER, M.D., Bloomfield

To have served The Medical Society of New Jersey as President for the past year has been an honor and a privilege for me. By the very nature of this office, it is a distinction which can be conferred upon only a few physicians and one which any member of our Society would be proud to fill. It has been most gratifying to me to have had the close cooperation and association with so many members of our Society.

The President's report is presented as a general review of some of the Society's major activities during the past year. The Medical Society of New Jersey is a complex organization with many functions, subdivisions and ramifications but with all its many activities there is one continuing basic theme—how to improve the quality of medical care for all of our people. Our Society works closely and harmoniously with its component County Societies and cooperates with all other State Societies through the American Medical Association to formulate medical policies and ethical standards for our entire profession.

Organized medicine in New Jersey long ago passed from a Society which concerned itself solely with the scientific aspects of medicine. Today it has become increasingly important to be constantly aware of the economic, social and political influences which are brought to bear on the practice of medicine.

In the past the physician included the social, economic, welfare and public health problems as a part of general medical care. Today with the rapid advances in scientific medicine, the average physician is no longer able to devote sufficient time to public health, social, and welfare problems. Because of the increasing need for these services numerous agencies interested in these respected fields have developed. These agencies share the same interests in the health and welfare of our people as do the physicians. Our Society has many liaison committees which work with these agencies.

The care of the aged, rehabilitation, and the increase in the number of poliomyelitis cases were some of the topics discussed with the State Department of Health. The control of poliomyelitis by cooperative action between our two groups was considered at great length, with recommendations for further study ranging from extensive surveys in low income areas with increased public education concerning the value of vaccination to legislation which would include vaccination as a requirement for public school attendance.

The economics of medical care is becoming more closely associated with prepayment health insurance plans. Medical costs continue to rise along with all other living costs. Specialization has also increased the cost of medical care. To meet these increasing costs third party participation has developed through prepayment plans for medical service by commercial insurance companies, medical-surgical plans, and health and welfare funds controlled by industry and labor. One of medicine's future

problems is to retain the control of the standards for the quality of medical care, which we also believe includes the right of the patient to have free choice of physician, and the fee for service principle.

Through our Subcommittee on Legislation our Society is constantly informed about proposed legislation on state and national levels which would tend to restrict or control the practice of medicine either directly or through imposed economic controls. Of current interest to all physicians is legislation which would provide some form of retirement plans for the self-employed and the inclusion of the medical profession under Social Security.

During the years many meetings were held to discuss the separation of professional fees for radiologists and pathologists from hospital costs. The problem is complicated because some professional fees are now included in the overall hospital service and are paid for as a hospital charge by Blue Cross, the commercial insurance companies and individuals. One of the major problems is that the radiologists and pathologists contend that their professional and technical services are all inclusive and cannot be separated. This opinion is concurred in by the American Medical Association and the American College of Radiology.

The recognition of the radiologists and pathologists as specialists and not hospital employees is another important step forward and one which is justly deserved. It is now generally accepted that their professional fees should be transferred from Blue Cross to Blue Shield. Blue Shield, however, can pay only for professional services and therefore cannot include the cost of technical services even though the radiologists and pathologists contend that the two services are all inclusive.

Numerous meetings have occurred between the representatives of the radiologists, pathologists, and the New Jersey Hospital Association, with the Medical Society acting as moderator. Representatives of Blue Cross and Blue Shield have also attended some of these meetings as observers and advisors. The problem is not an easy one but will eventually be solved by negotiation and compromise.

Other problems discussed between the Hospital Association and the Medical Society included the control of staphylococcus infections in hospitals, the overuse and abuse of hospital services and facilities, and the need for adequate facilities in general hospitals to care for acute mentally ill cases.

This year will complete the revision of the Constitution and Bylaws. Much confusion and ambiguity have been clarified and many errors of omission have been corrected. This has been a tremendous task and many thanks are due to the committee for their thoroughness, patience and perseverance. One of the main corrections, which will expedite the work of the convention, will be to permit the reference committees to make composite recommendations to the House of Delegates from the acceptable parts of several resolutions as submitted to the reference committees. Previously the reference committees could only recommend approval or disapproval of the resolutions as submitted.

As the result of a recommendation from the American Medical Association, the problem of medical care for persons over 65 with low incomes was considered by our Board of Trustees who recommended that the Medical-Surgical Plan of New Jersey prepare a new policy with reduced premiums and reduced fees to participating physicians for this group. A poll of the membership of our Society indicated overwhelming support for this proposal.

During the year the problem of administration of intravenous medication by nurses was discussed and a clarification of the authority of nurses to give intravenous medication was given by the State Board of Medical Examiners that "those who hold certificates as Registered Nurses may properly administer intravenous medications and/or other forms of intravenous therapy (including transfusions as well as infusions) when such are given under the specific direction of a regularly licensed physician or surgeon in each particular case. This authorization includes such procedures either in the hospital or elsewhere under the conditions stipulated. It is not necessary for the physician actually to be present in person when the intravenous medication or therapy is being administered."

The report further emphasized that the physician and Director of Nursing will have assured themselves that the nurses assigned to intravenous therapy are competently trained in the proper technics; that malpractice suits can involve the nurse as well as the physician and the hospital; and that instruction for intravenous therapy not be made a part of the regular training of undergraduate nurses but that graduate nurses with the requisite interest, aptitude, and skill be selected and specially trained.

I have not attempted to mention the tremendous amount of work that has been done by the many committees which have cooperated so willingly. Each of them will present

its own written report, and I urge all of you to read carefully the recommendation of these committees.

I should like to sincerely thank all the members of The Medical Society of New Jersey for the honor of representing them during the past year. I hope that I have fulfilled at least in part your expectations. Whatever has been accomplished is never done by the president alone, for without the loyal support of the officers, the trustees, the delegates, the committee chairmen, the Woman's Auxiliary, and the entire membership, little or nothing could be accomplished. I should like to thank the Executive Officer and the Administrative Secretary for their willingness and helpfulness at all times.

This has been a most rewarding experience for me and I am sincerely grateful for the wonderful cooperation I have received. It is my wish that The Medical Society of New Jersey will continue to enjoy the high esteem in which it is held throughout the state, that it will continue unswervingly to work for the right of every individual to have free choice of physician, and that it will continue to provide the highest quality of medical care for all of our people.

Adopted (page 470)

Secretary

(Reference Committee "A")

MARCUS H. GREIFINGER, M.D., Newark

Routinely the office of the Secretary has dealt with correspondence, telephone inquiries, and questionnaires as received.

The Secretary attended the annual meeting of the American Medical Association in San Francisco and the mid-winter meeting in Minneapolis, as well as the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1958)

Active-Paid	5,826
Exempt	226
Total Active	6,052
Associate	263
New and reinstated members	261
Members deceased	73
Transfers in state	14
Resignation and transfers out-of-state	29
State Emeritus	144
State Honorary	4
Members dropped for non-payment of dues	63
A.M.A. Members	5,551

A.M.A. MEMBERSHIP

Although the membership of The Medical Society of New Jersey at the close of 1958 totaled more than 6,000, the New Jersey membership in the A.M.A., while increasing, still has not reached the maximum which would entitle our Society to another delegate to the A.M.A. The A.M.A. delegation is based on one delegate per 1,000 members or fraction thereof, and the New Jersey delegation remains at six.

MEMBERSHIP DIRECTORY

The fourth edition of the Membership Directory—1959-1960—is in the process of compilation. It is anticipated that the directory will be mailed to the membership early in the summer of 1959.

With the approval of the Board of Trustees, the directory records are being converted into a card system. A new format has been approved for the next issue which will use an automatic page, photographic printing process. The result will be improved composition and legibility, a saving in future printing costs, and a reduction in staff time for compilation of directory data.

6,522 directory listings were mailed to the members with a request that corrections be noted and the listings be returned by March 1. As of the date of this report there has been only a 70 per cent return. Those members who have not returned their corrected listings are urged to do so at once. Likewise, those members who have not yet paid their 1959 assessments—approximately 8 per cent, or 487—are urged to make prompt payment in order that their names will be included in the directory.

Adopted (page 470)

Treasurer

(Reference Committee "B")

RUDOLPH C. SCHRETZMANN, M.D., Bergenfield

As the fiscal year does not close until May 31, 1959, a complete annual report cannot be submitted at this time. An interim report covering the accounts from June 1, 1958, through March 31, 1959, is presented below:

BALANCE SHEET — MARCH 31, 1959

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$174,773.95	
Executive Office Revolving Account	9,181.74	$183,955.69
Savings Accounts:		
Bloomfield Savings Bank, Bloomfield	$ 10,000.00	
Howard Savings Institution, Newark	10,000.00	
Morris County Savings Bank, Morristown	7,189.08	
Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	5,267.95	42,457.03
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$ 10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$276,412.72
Accounts Receivable		10,859.16
Inventory Maternal Welfare Record Books, at cost (contra)		1,358.81
Investments—U. S. Savings Bonds		27,500.00
Land, Buildings and Equipment (contra)		145,411.98
Total Assets		$461,542.67

LIABILITIES, RESERVES, AND SURPLUS

Employees' Payroll Deductions	$ 1,354.21
A.M.A. Dues Payable	50.00
Assessments Collected, Applicable to 1959-60	96,792.50
House Reserve	5,465.52
Annual Meeting Reserve	25,026.53
A.M.A. Dues Collection Reserve	190.24
Membership Directory Reserve	1,002.41
Journal Reserve	8,101.45
Land, Buildings and Equipment Reserve (contra)	145,411.98
Maternal Welfare Record Books Reserve (contra)	1,358.81
Unexpended Budget Accounts, 1958-59 fiscal year	45,670.68
Surplus	131,118.34
Total Liabilities, Reserves, and Surplus	$461,542.67

MEDICAL STUDENT LOAN FUND

Cash:		
General Account	$ 3,190.32	
Albert Barker Kump Memorial Grant	4,907.00	$ 8,097.32
Notes Receivable		10,675.35
Investments—U. S. Savings Bonds		16,528.27
Total		$ 35,300.94

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1958-59

JUNE 1, 1958 — MARCH 31, 1959

RECEIPTS

Cash on Hand, June 1, 1958				$247,653.37
Assessments:	AMA Dues	State Dues	Total	
Atlantic County	$ 3,600.00	$ 4,360.00	$ 7,960.00	
Bergen County	12,437.59	17,620.00	30,057.59	
Burlington County	2,175.00	3,650.00	5,825.00	
Camden County	7,650.00	9,550.00	17,200.00	
Cape May County	875.00	1,080.00	1,955.00	
Cumberland County	1,875.00	2,510.00	4,385.00	
Essex County	31,025.00	41,190.00	72,215.00	
Gloucester County	1,600.00	2,430.00	4,030.00	
Hudson County	12,625.00	16,690.00	29,315.00	
Hunterdon County	1,150.00	1,400.00	2,550.00	
Mercer County	8,825.00	10,687.00	19,512.00	
Middlesex County	7,025.00	8,600.00	15,625.00	
Monmouth County	5,600.00	8,080.00	13,680.00	
Morris County	5,650.00	7,040.00	12,690.00	
Ocean County	1,600.00	2,010.00	3,610.00	
Passaic County	10,625.00	15,600.00	26,225.00	
Salem County	1,175.00	1,410.00	2,585.00	
Somerset County	1,812.50	2,290.00	4,102.50	
Sussex County	1,025.00	1,300.00	2,325.00	
Union County	12,675.00	15,387.00	28,062.00	
Warren County	875.00	1,080.00	1,955.00	
Total Assessments	$131,900.00	$173,964.00	$305,864.00	
A.M.A. Dues Refunds			262.50	
Journal Advertising, net			50,587.95	
Annual Meeting Exhibits			18,100.00	
Interest			3,668.02	
Sale of Maternal Welfare Books			915.19	
Rents			220.00	
Payroll Deductions			1,354.21	
Refunds of Budget Expenses 1958-59			374.57	
Janitorial Services			55.00	
Hospital Service Plan			250.64	
A.M.A. Dues Collection			162.11	
Medical Student Loan Fund—Transfer			1,487.72	
Membership Directory			643.39	
Refunds of Budget Expenses—1957-58			91.65	
Dues Assessments from Prior Year			35.00	
Insurance Claim			428.82	
Accounts Receivable Collected			860.68	
Total Receipts				385,361.45
Total				$633,014.82

DISBURSEMENTS

Budget Accounts:		
A-1	Executive Salaries	$ 36,663.52
A-2	Executive Office Salaries	28,527.83
A-3	Executive Office Expenses	1,204.80
A-4	Executive Office Travel	2,345.47
A-5	House Maintenance	11,147.83
A-6	Treasurer	2,248.61
A-7	Finance and Budget	35.28
A-8	Secretary	1,445.93
A-9	Payroll Taxes	1,245.22
A-10	Insurance	1,290.42
C-1	Welfare Committee	520.48
C-2	Legislative Committee	2,978.17
C-3	Public Health Committee	780.35
C-4	Public Relations Committee	5,025.67
C-5	Medical Practice Committee	959.10

D-1	President and Presidential Officers	4,066.33
D-2	A.M.A. Delegates	6,390.72
D-3	Woman's Auxiliary	7,011.04
D-5	Liaison Committees	48.50
D-6	Directory, Membership, Physicians Placement	948.10
D-7	Civil Defense-Disaster Control Committee	16.02
D-8	American Medical Education Foundation	25,000.00
D-11	Medical Defense and Insurance Committee	10.13
E-1	Board of Trustees	1,300.25
E-2	Contingent	3,106.73
E-3	Judicial Council	586.26
E-4	Legal	2,643.34

Total Budget Accounts	$147,546.10
Accounts Payable, May 31, 1958	12,405.69
Journal Publication	48,182.22
Journal Office Expenses	456.79
Annual Meeting	6,161.82
Journal Commissions	3,309.89
Janitorial Services	65.00
A.M.A. Dues Collection	253.86
Assessments Refunded	1,580.00
A.M.A. Dues	132,112.50
House Reserve	4,260.73
Budget Expenses for 1957-58	267.50
Total Disbursements	$356,602.10
General Cash Balance, March 31, 1959	276,412.72
Total	$633,014.82

SHORT-TERM INVESTMENTS

As recommended by the House of Delegates last year, some short-term investments have been made from the general fund—$25,000 in treasury bills, and $8,000 in treasury bonds. This procedure will be continued when market conditions and the balance in the checking account permit.

Adopted (page 472)

Board of Trustees

CARL N. WARE, M.D., Chairman, Shiloh

(Reference Committee "A")

Most of the Board's activities of the year have been published in THE JOURNAL, so this report will highlight only the major business considered and acted upon by the Board of Trustees. The Society's business has made heavy demands upon the time of the Trustees. Eight meetings will have been held before the Annual Meeting.

The Board members have served loyally and diligently. The numerous committees, by their orderly work and generous endeavors, have greatly facilitated the conduct of the Society's business.

The Board's activities, as will be noted from the following items, have been, in the majority of instances, concerned with specialized subjects, which are referred to other reference committees for consideration in connection with the main subjects to be considered by those reference committees.

Regularly the Board of Trustees has dealt with general matters brought to its attention —correspondence and resolutions from mem-

bers, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; nomination of candidates to the State Board of Medical Examiners; consideration of and action on the reports and recommendations of the several standing and special committees, including the Welfare Committee, its sub- and special committees; cooperation with the departments of the State government, and with the allied professions—dentistry, pharmacy, nursing, legal, and hospital administration.

Because of the Board's opinion, confirmed by counsel, that it was the intent of the Society's Constitution and Bylaws that the Board of Trustees be an 18-member body, and because of the vacancy existing on the Board in the place of immediate Past-President, occasioned by the death of Dr. Kump, Dr. Fritts was continued on the Board as the immediate Past-President for a period of one year.

The Board approved a suggestion of the President that Board actions be kept on a current five-year basis, and that its actions of the preceding five-year period be routinely reviewed and reconsidered if they are of a continuing nature.

A Doctor of Osteopathy has instituted civil action against a county society to compel it to grant him membership. The county society has asked assistance from The Medical Society of New Jersey in the defense. The Board unanimously voted to cooperate with the county society, and to that end authorized action on the part of the Society's legal counsel in the defense. The suit is against the county society only. In defense an answer was filed in Superior Court, and an attempt was made to obtain the necessary affidavits in support of a motion for summary judgment. This has not been possible. The State Board of Medical Examiners, on the opinion of the Attorney General, stated that it could not enter into a private suit. The Board of Medical Examiners thus declined to sign the requested affidavit concerning the license of the plaintiff.

The Board of Trustees instructed the A.M.A. Delegates to see that some recommendation was brought before the A.M.A. House of Delegates urging that its Board of Trustees utilize the services of the Past-President on the Board by inviting him to all meetings of the Board and giving the right of voice. Such a resolution was introduced by the Vermont delegation and supported by our delegates. However, the resolution was disapproved on the opinion of the reference committee that the purpose is already accomplished through that section of the A.M.A. Bylaws which makes the immediate past-president an *ex officio* member of the Council on Medical Service.

Adopted (page 470)

MEDICAL STUDENT LOAN FUND

(Reference Committee "B")

The Board of Trustees is of the opinion that the Medical Student Loan Fund of The Medical Society of New Jersey should be self-perpetuating. To help bring this about, the Board adopted the following recommendations and referred them to the Finance and Budget Committee:

1. That an appropriation of $5,000 each year be included in the budget to maintain the Medical Student Loan Fund.

2. That for this year (1958-59) the interest income from investments be paid into the Medical Student Loan Fund.

Adopted (page 472)

BLUE CROSS INTER-PLAN SERVICE BANK

(Reference Committee "C")

The House of Delegates last year approved the resolution from the Union County Medical Society and the recommendation of the reference committee that Blue Cross be invited to submit for publication in THE JOURNAL the clarifying details of the Inter-Plan Service Bank.

The resolution was referred to the Permanent Committee on Blue Shield-Blue Cross Plans, and Blue Cross provided the article for THE JOURNAL, which was published in the October, 1958 issue, page 582.

Adopted (page 473)

HEALTH CARE OF THE AGED

(Reference Committee "C")

The Board of Trustees recorded its approval and support of the A.M.A. recommendations regarding special health insurance coverage for people over 65 years of age with modest resources and reduced incomes. The following recommendations were adopted:

1. That Blue Shield with all possible speed prepare a contract offering coverage at reduced premiums to this group, and that the proposed contract be submitted to the Commissioner of Banking and Insurance for his approval at the earliest possible date.

2. That the physicians of New Jersey cooperate by accepting the levels of payment established in the proposed new coverage.

3. That it be suggested to Blue Cross that careful consideration be given to the writing of a new contract at a reduced premium for those over 65 with reduced incomes and modest resources, in order that they can adequately provide for their hospital care.

4. That it be suggested to the New Jersey Hospital Association that it cooperate with The Medical Society of New Jersey, and with the Blue Shield and Blue Cross Plans, in offering the services of the hospitals in this State at reduced rates to those over 65 with limited means.

Medical-Surgical Plan reported that a new contract for the over-age group was in the process of preparation and that it was hopeful that such a contract could be sold at a lower premium—about 30 per cent less than the regular contract. It was proposed that the income limits would be reduced to $2,500 for a single person and $3,000 for husband and wife, Plan payment would be full payment to participating physicians, and these payments, of course, would be lower than under the regular contract.

Hospital Service Plan commended the Society for following so quickly the recommendation of the A.M.A., and assured the Board of the fullest cooperation in implementing the program insofar as may be consistent.

The New Jersey Hospital Association expressed great interest in the problem, and reported that it encourages all member hospitals to make adequate provisions for the care of this age group, but that it fails to see how non-profit institutions which usually operate with sizeable deficits can reduce their rates for an increasing proportion of the hospital population.

The Board of Trustees did not regard as acceptable the contention that the financial status of the hospitals of New Jersey make impossible any reductions in costs for this group. It felt that failure to supply hospital services at reduced costs to the needy will render fruitless any and all other efforts to supply their needs, short of by adoption of legislation such as the Forand bill.

A second letter was sent to the Hospital Association embodying the Board's expressions and requesting the Association to reconsider the entire matter and make every effort to cooperate in this endeavor. A reply from the Hospital Association stated it is willing to consider any reasonable measure to provide hospital care at reduced costs for the over-age group, and in order that the problem can be fully explored with representatives of the Medical Society the matter has been referred to the Hospital-Medical Liaison Committee.

Referred back to the Board of Trustees for further study with power to act (page 473)

MEDICAL SERVICE ADMINISTRATION

(Reference Committee "C")

Approved was the nomination of Irving P. Borsher, M.D., to the Board of Governors, Medical Service Administration, to fill the vacancy created by the resignation of William F. Costello, M.D.

The following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey for 1959-60 were approved by the Board of Trustees of The Medical Society of New Jersey, and are referred to the House of Delegates for action:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Adopted (page 473)

MEDICAL-SURGICAL PLAN

(Reference Committee "C")

The nominations of four new members to the Board of Trustees of Medical-Surgical Plan for 1958-59 were approved:

Jerome G. Kaufman, M.D., Newark
Samuel J. Lloyd, M.D., Trenton
Charles L. Cunniff, M.D., Jersey City
Glennis S. Rickert, M.D., Boonton

The following nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey for 1959-60 were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Robert G. Boyd

Charles L. Cunniff, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Jerome G. Kaufman, M.D.
Joseph M. Keating, M.D.
Samuel J. Lloyd, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Duane E. Minard, Jr.
Glennis S. Rickert, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
James H. Spencer, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers

Adopted (page 473)

MEDICARE PROGRAM

(Reference Committee "C")

The special committee appointed by the Board to deal with problems arising out of the Medicare program early last fall completed the arduous and time-consuming task of revising the schedule of benefits, not only in the matter of fees, but also in format; and although the program was to be curtailed on October 1, 1958, because of a cut-back in funds, a full fee schedule was re-negotiated by the special committee in the hope that more funds would be available in 1959 to return the program to its original coverage. The committee continued to consider disputed claims, and supplemental agreements to the contract. In its two years of work, the committee has considered 175 disputed claims. It is encouraging to note that of this number, 137 recommendations of the committee were accepted by Washington and payment made accordingly, 24 recommendations for payment were disapproved, and only 14 cases are still pending. The number of disputed claims in the second year of the program has decreased—114 in the first year to 51 in the second year. The committee is to be commended for its diligence and efforts in behalf of the members of the Medical Society.

Adopted (page 473)

LIABILITY COUNTERSUIT

(Reference Committee "D")

A member requested that The Medical Society of New Jersey be a party to a countersuit against a plaintiff and her lawyers under the terms of S-234 (1956), inasmuch as the original action was dismissed by the court on the grounds of no cause. The Medical Defense and Insurance Committee urged that action be taken by the Society, emphasizing that it is not money, but vindication, that doctors are seeking, and that by utilizing this approach the Society will undoubtedly prevent some future liability cases which are growing in volume and severity. Resolutions from the Bergen and Hudson County Medical Societies also urged action on the part of the Society. The request was referred to the Society's legal counsel for opinion. He reported that the insurance carrier would not participate in any action against the plaintiff or her lawyers. The physician had not taken any action himself. Counsel suggested that if it is desirable to set a precedent under the statutes in question, as a deterrent to others who might litigate imprudently, this is not the set of facts on which the Society should move to accomplish that end, because there is no evidence that the charge was made "falsely and maliciously." Counsel, therefore, advised that the Society neither join with the physician nor act itself. The report of counsel was approved by the Board of Trustees and the member was notified of counsel's opinion and the action taken.

Adopted (page 474)

EXAMINATION OF HOSPITAL RECORDS

(Reference Committee "E")

The 1958 House of Delegates approved the intent of the resolution from the Middlesex County Medical Society calling for an amendment to Chapter 286, P. L. 1945; and the House recommended that further consideration of the resolution be given by the Board of Trustees.

The Society's legal counsel reviewed the resolution, together with the opinion of the Society's legislative analyst, which was reported at the 1958 House of Delegates.

Counsel expressed agreement with the legislative analyst, who said that the statute as written can adequately protect hospitals provided the hospitals prepare and enforce reasonable rules and regulations. Originally, consent in writing was necessary, and if denied, the recourse was in the courts of law. The statute makes it more lenient. However, the entire problem can be controlled and regulated by the rules and regulations of the hospital itself. If this is done, no hospital should ever worry about it.

The Board of Trustees reaffirmed its approval of the opinion of the legislative analyst and directed that a copy of the resolution be sent to the New Jersey Hospital Association with a request that its member hospitals be

apprised of the desirability of carefully drawing rules and regulations regarding the examination of hospital records and adhering to them; and that the Middlesex County Medical Society be informed of the action taken and of the opinion expressed by counsel.

A reply from the New Jersey Hospital Association to the Board's communication stated that the forms in use had been studied, and that the present Code of Practice for examination of hospital records had been reviewed by the Association's counsel and the Council of Administrative Practice. The Association sent a letter to its member-hospitals stressing the importance of observing the Hospital Records Law of New Jersey, together with a copy of the Code of Practice for the examination of hospital medical records based on the provisions of Chapter 286, P. L. 1945 (R. S. 2a:82-41), and a copy of a suggested authorization form.

Adopted (page 475)

INTRAVENOUS MEDICATION BY NURSES

(Reference Committee "E")

At the request of the New Jersey State Board of Nurses' Examiners, Medical Society representatives met with representatives of the State Board of Medical Examiners, the State Board of Nurses' Examiners, and the Attorney General's office concerning the several resolutions and the opinion from the Attorney General's office on the matter of nurses' giving intravenous medications, about which the nurses had requested clarification.

A statement from the State Board of Medical Examiners was published in the March issue of the *Membership News Letter*, and the April issue of THE JOURNAL, so that all members will be aware of the State Board's opinion in the matter. In brief, " . . . it is the opinion of the State Board of Medical Examiners of New Jersey that persons who have been duly licensed as 'professional nurse'—*i.e.*, those who hold certificates as Registered Nurses—may properly administer intravenous medications and/or other forms of intravenous therapy (including transfusions as well as infusions) when such are given under the specific direction of a regularly licensed physician or surgeon in each particular case. This authorization includes such procedures either in the hospital or elsewhere under the conditions stipulated. It is not necessary for the physician actually to be present in person when the intravenous medication or therapy is being administered . . . "

Adopted (page 475)

PRE-SCHOOL INOCULATIONS AND VACCINATIONS

(Reference Committee "E")

A recommendation, originating with the Special Committee on Child Health and approved by the Subcommittee on Public Health, urged the Medical Society to encourage local boards of education and local private school authorities to require inoculations against polio for all children attending school. Concurrently representatives of the State Society attended a conference jointly sponsored by the State Department of Health and the State Department of Education, with representatives of the New Jersey Academy of Pediatrics, New Jersey State Nurses' Association, the League of Nursing, the Congress of Parents and Teachers of New Jersey, the New Jersey Association of Women's Clubs, and other agencies to discuss the high incidence of polio which continues in New Jersey, and to consider by what means the indifference of the public toward the Salk inoculation program could be combated, specifically as regards children up to ten years of age, and adult males from 20 to 29.

The following recommendation was adopted by the Board of Trustees and sent to component societies and the agencies represented at the joint conference:

> The Medical Society of New Jersey—recognizing the fact that certain communities do not require vaccination against poliomyelitis and diphtheria as a prerequisite to school attendance, and recognizing the fact that such requirement can only be imposed through the action of local Boards of Education and private school authorities in conjunction with the school physicians—recommends that each component county medical society review the situation within its boundaries and, where necessary, take steps to encourage local Boards of Education and private school authorities to adopt the requirement of immunization against diphtheria and poliomyelitis as a prerequisite for school attendance.
>
> It is the further recommendation of The Medical Society of New Jersey that the component county medical societies also urge local Boards of Education and private school authorities to require the following inoculations as a prerequisite for admission to school: tetanus, smallpox, and pertussis.

Adopted (page 475)

SOCIAL SECURITY FOR PHYSICIANS

(Reference Committee "E")

It is the opinion of the Board of Trustees, and it so recommends to the House of Delegates, that those counties which have not recently polled their membership on social security should do so. It is suggested that when

such polls have been conducted, the county societies report actual figures, *i.e.*, number polled, number of replies received, and the number voting for and against the inclusion of physicians under social security.

In order that we may have accurate and consistent detailed reports for the record, the component societies were solicited for information on whether they had canvassed their members since May of 1957 on the subject of the compulsory inclusion of physicians under Social Security. Five counties reported they had not; two counties have not yet replied, and 14 counties reported polls had been taken. The totals of the polls taken are:

Number of ballots mailed	4,841
Number of ballots returned	3,466

Of the returned ballots:

Number favoring such inclusion	2,174
Number opposed to such inclusion	916
Number already covered	340
Number undecided or not voting	36

Adopted (page 475)

TECHNICAL SERVICES BY NON-PROFESSIONAL PERSONNEL

(Reference Committee "E")

The Board's attention was called to an opinion of the Attorney General concerning the taking of electrocardiograms by a laboratory technician or a laboratory director. Unless the same is performed under the direct supervision of a duly licensed physician and/or surgeon of this State, the opinion stated that ". . . the taking of electrocardiograms by the above mentioned groups is not legal and this practice must cease at once."

The Board of Trustees requested the Subcommittee on Legislation to look into the problem of technical services by non-professional personnel and the Medical Practice Act, and directed that the entire scope be reviewed and clarified.

The subcommittee discussed the subject in conference with the State Board of Medical Examiners and the Attorney General's office. A communication from the State Board of Medical Examiners stated " . . . X-ray technicians, laboratory technicians or other technical assistants . . . are not excepted from the prohibitory provisions of the Statute . . . no person not specifically excepted such as X-ray technicians and laboratory technicians is exempt. The only way that exemption can be secured for these groups is by specific amendment of the Medical Practice Act."

It was the action of the Board of Trustees that such an amendment be included in the Medical Practice Act and the Subcommittee on Legislation has prepared an appropriate amendment which the Board has approved.

Reference committee recommendation that matter be referred back to Board of Trustees for further study—Adopted (page 476)

Supplemental Report

MEDICAL-LEGAL TESTIMONY

(Reference Committee "A")

1. *Code for Physicians and Attorneys*

The Special Committee on Medical-Legal Testimony, continuing its effort toward the formation of a code governing standards of practice of lawyers and doctors, recommended the adoption of the "National Inter-Professional Code for Physicians and Attorneys," and commentaries thereon as they relate to The Medical Society of New Jersey. The commentaries were prepared by the Society's legal counsel.

The Board of Trustees approved the Code and the commentaries, and directed that both be published in full in THE JOURNAL. (page 134, March, 1959, issue), that copies be sent to the component county societies, and that the component county societies be urged to achieve the adoption of the Code at local levels. Bergen County reported adoption of the Code at its March meeting.

The special committee reported that a committee of the New Jersey Bar Association has agreed to recommend to its House of Delegates the approval of the National Inter-Professional Code for Physicians and Attorneys.

Adopted (page 471)

2. *Impartial Medical Witnesses*

The special committee proposed a resolution which would empower it to confer with the Chief Justice of the Supreme Court of New Jersey and/or the Administrator of the Courts, for the purpose of urging that the Supreme Court consider changing its rules so as to permit the members of a panel of impartial medical witnesses, set up by The Medical Society of New Jersey to be available at the call of the Court, to examine and give testimony in cases in which there is marked divergence of medical professional opinion.

The following resolution was adopted by the Board of Trustees and is *recommended* for adoption by the House of Delegates:

Whereas, A high percentage of litigated cases today involves the taking of medical testimony, and

Whereas, There is in many cases a wide divergence of medical opinion expressed in such testimony by partisan physicians, and

Whereas, The medical profession and this Society are interested in avoiding criticism directed against physicians and the profession as the result of such divergence of opinion, and in seeing that justice is furthered and not impeded by the medical testimony given; now therefore be it

Resolved, that The Medical Society of New Jersey empower the Special Committee on Medical-Legal Testimony to confer with the Chief Justice of the Supreme Court of New Jersey, and/or the Administrator of the Courts, for the purpose of urging that the Supreme Court consider changing its rules so as to permit the members of a panel of impartial medical witnesses, set up by The Medical Society of New Jersey, to be available, at the call of the Court, *in cases in which there is marked divergence of medical professional opinion.*

Adopted (page 471)

MEDICAL-SURGICAL PLAN
(Reference Committee "C")

1. *Payment to Chiropodists*

Medical-Surgical Plan reported that on November 25, 1958, it had finally adopted a resolution authorizing payment by the Plan to licensed chiropodists for eligible services rendered within the scope of their practice to persons enrolled with the Plan. This action was taken following consultation with the Commissioner of Banking and Insurance concerning compliance with the 1953 supplement to the Enabling Act (Chapter 283, P.L. 1953), which provides that payment shall be made for eligible services when rendered by licensed chiropodists. It was the directive of the Commissioner that the word "shall" made it mandatory, not permissive, for Medical-Surgical Plan to include chiropodists in the Plan. At the present time the eligible services of chiropodists are limited to those performed by hospital staff members.

The Board of Trustees—being of the opinion that in a new contract chiropodists might provide unlimited services out of the hospitals, and that other groups might also come to be included in the Plan—referred the matter to the Subcommittee on Legislation for consideration of rescinding the 1953 amendment to the Enabling Act.

The Legislative Analyst, at the request of the subcommittee commented: "The practice of chiropody as defined by R.S. 45:5-7 is quite limited . . . It follows therefore that the opportunity for chiropodists to avail themselves of the law in question is as limited as their practice . . . In view of the limited extent to which chiropodists may avail themselves of the benefits under existing law, the advantages enuring to the Medical Society from *not* repealing the law in question far outweigh the possible benefits to some few of its members if the law were repealed . . . If this law is to be repealed it must be shown that the legislature erred in 1953 to the detriment of the general public. The facts as I understand them would not support such a conclusion."

The Subcommittee on Legislation and the Board of Trustees approved the report and recommendation of the Legislative Analyst, for the reasons set forth in that report.

Approved. Reference committee indicated dissatisfaction with 1953 Amendment to Enabling Act; recommended matter be referred back to a proper committee for further consideration; attention invited to 1958 action of the House: "The Board of Trustees, etc."—Adopted (page 473)

2. *Contract Inequities*

The 1958 House of Delegates directed that legal counsel be requested for an opinion on items relating to multiple surgical-type coverage, third-party liability, and income classification with respect to recommending to the Blue Shield Board of Trustees the inclusion of these items in the present contract; if it is not possible, then these items are to be included in any type of contract to be subsequently issued.

The following report has been received from Legal Counsel, Mr. Backes:

My research has included a study of the Manual for Participating Physicians, the form of the present Medical-Surgical Contract, and conferences and correspondence with William Vanderbilt, the legal counsel for the Plan and Dr Altano, their executive Vice-President.

The annual report of the Medical-Surgical Plan relates, under Prospects for Future Evolution, five proposed changes for inclusion in a new subscription contract. Items four and five thereof pertain to Multiple Health and Accident Insurance Coverage, Third Party Liability, and Income Limits. These are the same three items recommended by the Middlesex County resolution (likewise the resolution from Passaic and Hudson) for inclusion in the current or subse-

quent contracts. It is obvious that the Plan is making the necessary effort to comply with the wishes expressed on the floor of the House of Delegates last year, by proposing that the three items be included in a subsequent contract. My investigation discloses that it is intended, in the future, to require that the subscriber notify the doctor initially that he is covered, or not, by the Plan and that his income is under or over $7,500 annually. It is also intended that the subscriber shall report his annual income, before taxes, from all sources. In the case of third party liability actions where judgment is obtained, as in the case of multiple plan coverage, it is intended that the participating physician will be paid his scheduled amount and also that he will be allowed to bill the patient the difference between the scheduled payment and his appropriate fee.

As indicated in the annual report of the Medical-Surgical Plan, the issuance of a new subscription contract is a tremendous undertaking and necessarily is time consuming. At the present time, recommendations are being put in final form by the Contract Review Committee of the Plan for submission to the Board of Trustees of the Plan in approximately six weeks. Subsequent to the approval by the Board of Trustees, the contract will be submitted to the actuaries for computation of the rate. The final step then, is to seek approval of the Department of Banking and Insurance. It is not fair to estimate the length of time required for final approval.

It is my opinion that the desired items cannot be excluded in the current contract, and further that the possibility of their being included in a future contract, is increased by compensating benefits proposed for subscribers.

Adopted (page 474)

ACCREDITATION OF HOSPITALS AND INTERN AND RESIDENT TRAINING PROGRAMS
(Reference Committee "D")

The following resolution, adopted by the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was favorably received by the Board of Trustees last November, and the N. J. Delegates to the A.M.A. were instructed to support it. The resolution was *not* introduced at the last Clinical Meeting of the A.M.A., but it is expected to be introduced at the Atlantic City meeting in June. The New Jersey Chapter of the American Academy of General Practice favorably passed on the resolution at its recent annual meeting. The Board of Trustees reaffirmed its action of last November, recommends its adoption by the House of Delegates and support by the New Jersey Delegates in the A.M.A. House of Delegates.

Whereas, the Medical and Chirurgical Faculty of the State of Maryland seeks to further the primary function and chief responsibility of hospitals in the State of Maryland so as to permit them to achieve greater efficiency in the care of patients and training of house officers; and

Whereas, the Faculty believes that there should be no derogation of these two aims; and

Whereas, it is the sense of the Faculty that these objectives can be accomplished by a realistic approach to hospital accreditation with due weight and regard to factors of regional significance and the experience, opinions and findings of local medical societies; and

Whereas, the incidents of accreditation presently require the physician to divert time and attention from patient care in order to attend local and routine gatherings to the exclusion of City, State and National meetings; prepare schedules, charts, notes and other record minutiae and attend unnecessary hospital staff meetings and conferences; and

Whereas, the demands of accreditation force a smaller hospital to affiliate with a larger institution which usurps the trained personnel of the affiliate; and

Whereas, subspecialties are overemphasized at the expense of in- and out-patient examinations and floating residencies are encouraged; and

Whereas, the existing practices of accreditation limit the physicians' opportunity to visit various hospitals, thus depriving them of an important aspect of the educational process and the opportunity of broadening experience; discourages diversification of hospitals—large, small, medical school and non-medical school; prevents the hospital from retaining and developing the character and individuality desirable if competent interns and personnel are to be attracted to it; and

Whereas, hospital status and value should be determined by criteria other than more standardization, conformity, number of publications or amount of research; and

Whereas, the present methods of accreditation favor the large endowed institutions which are apt to become embroiled in differences of opinions on medical policies to a greater degree than smaller hospitals; and

Whereas, the requirements of accreditation tend to reduce the number of available beds by making it difficult if not impossible for the small institution to exist and results in the reservation of available beds to a limited number of physicians thereby depriving others of semi-private privileges while circumscribing or denying staff privileges and dictating the conditions of hospital attendance and staff affiliation; and

Whereas, the procedures of accreditation have made the procurement of interns difficult; have caused undesirable competition between hospitals for available personnel; have raided small hospital staffs through affiliation and have resulted in interns becoming generally unavailable when called because of affiliate duty or attendance at courses or lectures; and

Whereas, requests to the Commission on Accreditation of Hospitals and to the Council on Medical Education and Hospitals, not only for accreditation but also for assistance with prob-

lems incident thereto result in long delays, in little tangible aid and frequently merely lead to onerous demands, now, therefore be it

Resolved, 1. The Medical and Chirurgical Faculty of the State of Maryland based on its collective experience and study, hereby makes a finding of fact that the presently existing methods of approving and disapproving hospitals for accreditation adversely affect the potentialities and effectiveness of such institutions generally and the resident, intern and visiting physicians associated with such hospitals specifically;

2. The Commission on Accreditation of Hospitals and the Council on Medical Education and Hospitals review and reconsider their objectives and their procedures and evaluation methods in achieving such objectives;

3. The opinions and findings of local medical societies be given more weight in appraising hospital facilities and services for accreditation; and be it further

Resolved, that the Secretary of the Medical and Chirurgical Faculty be instructed to transmit copies of this resolution to all Component Societies of the American Medical Association for their information and appropriate action. Such appropriate action, it is hoped, will include the forwarding of similar resolutions in democratic action to the Joint Commission on Accreditation of Hospitals and to the Council on Medical Education and Hospitals of the A.M.A.; and that this resolution be placed in the hands of the Medical and Chirurgical Faculty's Liaison Committee on Accreditation of Hospitals for implementation.

Disapproved (page 474)

BLOOD BANK COMMISSION
(Reference Committee "E")

As reported last year, the New Jersey Blood Bank Commission—the Society's official agent in all matters relating to blood supply, etc.—recommended that The Medical Society of New Jersey "initiate legislation for the control of blood banks and blood bank practices within the State of New Jersey." This recommendation was referred to the Subcommittee on Legislation for study and report.

Because of the complexity of the problem involved, the subcommittee felt that before legislation was introduced or its preparation begun, there should be unanimity of opinion as to the necessity for and character of such legislation. To this end, the subcommittee decided to request that a consultative or exploratory conference be held to which should be invited representatives of the Subcommittee on Legislation, the State Department of Health, the Blood Bank Commission, commercial blood banks, and representatives of selected typical hospitals from various areas of the State. The chairman of the Blood Bank Commission was acquainted with the subcommittee's recommendation and requested to call such a conference, in the arrangements for which the subcommittee offered to cooperate.

However, the subcommittee was subsequently notified that the Blood Bank Commission had adopted the opinion that "blood banking in all its aspects is a form of medical practice, and, therefore, its control and regulation should fall within the province of the Board of Medical Examiners and the State Medical Society rather than within the State Legislature." The subcommittee therefore concluded that the original recommendation that the Society initiate legislation had been retracted and the subcommittee's assignment thereby cancelled.

The Blood Bank Commission now recommends "to the State Medical Society that it seek, through the appropriate channel, an official interpretation of the Medical Practice Act in regard to the following aspects of blood banking: selection of donors—collection, storage, and processing of blood and its component parts—and the administration of blood to a recipient." The Board of Trustees has directed a letter of inquiry on this matter to the State Board of Medical Examiners.

Adopted (page 476)

NURSING HOMES FOR THE AGED AND THE CHRONICALLY ILL
(Reference Committee "E")

A resolution from the Bergen County Medical Society, received by the Board of Trustees at its January meeting, was referred to a special committee—Dr. Wegryn, chairman—for study and report.

The special committee reported that after careful study of the resolution, its opinion was that the proposal was a novel idea and highly commendable, but impracticable. The committee's opinion and the value of the resolution were also discussed with the sponsor. However, the sponsor requested that the resolution as presented be submitted to the House of Delegates.

Adopted (page 476)

The Board of Trustees approved the report of the special committee and herewith submits the resolution without recommendation for the consideration of the House of Delegates:

Whereas, the aged are increasing proportionately in our population, and

Whereas, the problem of domiciliary care of the aged and the chronically ill is becoming increasingly burdensome on society, and

Whereas, many of the aged without relatives

are so infirm or ill that they are unable to care for themselves, and

Whereas, there is an increasing tendency for governmental agencies to build homes for the aged and the chronically ill to be operated at perpetual public expense, therefore be it

Resolved, that The Medical Society of New Jersey look into the matter of creating a non-profit, charitable corporation with the assistance of trained laymen and civic leaders, to obtain private, foundation, and public funds for the construction of modern, well-planned nursing homes for the aged and infirm to be operated at cost, and not for profit, by the corporation throughout the State of New Jersey; these nursing homes to be:

1. Modern, one-story, well-planned units, without steps or ramps, and with extra-wide doors and corridors;

2. Units consisting of no more than fifty to sixty beds, constructed in four-bed, two-bed, and single-bed rooms with the necessary ancillary services;

3. Preferably, in urban or suburban locations, close to hospitals for the convenience of visiting physicians and near public transportation facilities for the convenience of nurses and other employees or visitors;

4. Controlled by a central board of managers to which the State and its component County Medical Societies shall elect trustees annually, who shall serve without pay, with an equal number of lay trustees, who shall select paid personnel and who shall be directly responsible for the operative management of these homes;

5. Economically operated by centralized purchase of equipment and supplies, bookkeeping, etc., with a degree of centralized control in policies as to management and operation, and with some delegation of discretionary power to the local county board of managers over the nursing homes within its borders;

6. Licensed by the New Jersey State Department of Institutions and Agencies, as presently required by law, to be maintained at standards over and above the minimum as required, and consistent with the purposes for which the corporation would be chartered;

7. Operated at minimum fees for services, the charges for such care to be kept at the lowest possible level according to the type of accommodation and consistent with the non-profit, self-sustaining purpose of the corporation;

8. Inspected monthly by a visitor's committee from the local county medical society and lay board members which shall report to the component County Medical Society and the local Board of Managers of the corporation as to its findings, with recommendations, if any; and be it further

Resolved, that a copy of this Resolution be sent to the New Jersey State Department of Institutions and Agencies and to the several County Boards of Chosen Freeholders to request their aid in the implementation of this plan if acceptable to The Medical Society of New Jersey.

Reference: "Nursing Homes Prove High Standards Pay," by Edith M. Stern, in The Modern Hospital, 91:93 (Oct.) 1958.

Resolution disapproved (page 476)

TUBERCULOSIS SCREENING OF SCHOOL CHILDREN

(Reference Committee "E")

In response to several requests for recommended procedures in the tuberculosis screening of school children, recommendations were developed and adopted last fall. Recently representatives from the Society attended a joint meeting of the Interdepartmental Committee of the State Departments of Health and Education with representatives of the Academy of Pediatrics, the Parents and Teachers Association, and the Tuberculosis and Health Association to consider proposed recommendations for the tuberculosis screening of school population, which recommendations were developed as a result of a pilot study in Mercer County. The Society's recommendations of last fall did not include Mantoux testing of children in the elementary grades. However, as a result of the Mercer County pilot study, the percentage of reactors in the lower grades was shown to be significantly high enough to justify Mantoux testing of elementary school children in the urban areas. The recommendations of the State Interdepartmental Committee extend beyond the Society's recommendations.

The following action was taken by the assembled representatives at the Joint meeting:

> It is resolved that this advisory committee recommend to The Medical Society of New Jersey, the New Jersey Academy of Pediatrics, the New Jersey Tuberculosis and Health Association, and the State Departments of Education and Health that "Proposed Recommendations for Tuberculosis Screening of School Populations (After Pilot Study)" be considered by their separate boards for affirmative action. It is the consensus of this advisory committee that such a pilot study of one year duration will contribute to the development of rules leading to the eventual eradication of tuberculosis. The results of this pilot study are to be reviewed one year hence. The action of this advisory committee is not to be construed as representing action on the part of the organizations represented.

Following review of the proposed recommendations by a special committee, the Board of Trustees approved the "Proposed Recommendations for Tuberculosis Screening of School Populations (After Pilot Study)."

Adopted (page 476)

BUDGETARY ALLOTMENT FOR MEDICAL SERVICE ADMINISTRATION

(Reference Committee "B")

Subsequent to the preparation of the proposed budget for 1959-60 by the Finance and Budget Committee, the Board received a request from Medical Service Administration that the 1959-60 budget provide an allotment of $5,000 for Medical Service Administration to help meet its operating expenses.

In considering this request, the Board carefully weighed the following facts:

1. In the past twenty years The Medical Society of New Jersey has contributed over $150,000 to Medical Service Administration;
2. In this period Medical Service Administration has continuously administered a welfare program local to Newark, and—for a period of two or three years—also administered a state-wide veterans program;
3. That The Medical Society of New Jersey designated Medical Service Administration as its fiscal agent for the administration of the Medicare Program in New Jersey; and
4. That it did so with the assured expectation that the administrative costs underwritten by the government under the program would and should be sufficient to cover the costs of operation of Medical Service Administration.

In view of the foregoing considerations, the Board of Trustees concluded that further subsidization from The Medical Society of New Jersey should not be necessary and is not justified. Accordingly, the Board unanimously voted to deny the request of Medical Service Administration for the inclusion in the 1959-60 budget of an allotment of $5,000.

Adopted (page 472)

FOREIGN MEDICAL SCHOOLS

(Reference Committee "D")

The Board of Trustees, at its meeting on April 24, 1959, approved the request of the State Board of Medical Examiners as expressed in the following resolution:

Whereas, In February 1958, the Council on Medical Education and Hospitals of the A.M.A. and Executive Council of the Association of American Medical Colleges acted to withdraw on January 1, 1960, the current list of foreign Medical Schools for whose Graduates the Councils have recommended consideration on a basis comparable to that of approved Medical Schools in the United States and Canada, and

Whereas, the Councils report this action reflects their inability to acquire and maintain a continuing adequate knowledge of educational programs of all foreign Medical Schools whose graduates come from the United States, and

Whereas, the Educational Council for Foreign Medical Graduates by its stated principles will not attempt to evaluate teaching programs or inspect or approve any foreign Medical School, its program being based not upon evaluation of the school from which the candidate graduated but upon evaluation of the professional competence of the individual, and

Whereas, the Council on Medical Education and Hospitals of the A.M.A. and the Council of the Association of American Medical Colleges has now recommended that "licensing Boards consider certification by the Educational Council for Foreign Graduates as evidence that the recipient of such certification is possessed of medical knowledge comparable to that expected of graduates of approved medical schools in the United States," thereby setting two standards, one for the Graduate in the United States whose Medical School must undergo rigid inspection and approval and another for the foreign school graduate who must only pass the multiple choice examination of the Educational Council for Foreign Medical Graduates, and

Whereas, the State Board of Medical Examiners of New Jersey has requested that the A.M.A. Delegates from New Jersey be instructed to introduce a resolution urging the A.M.A. to devise a reliable method of determining the acceptability of Foreign Medical School programs and to set up a means of inspection of Foreign Medical Schools, therefore be it

Resolved, that the Board of Trustees request the House of Delegates of The Medical Society of New Jersey to instruct the A.M.A. Delegates from New Jersey to the A.M.A. to introduce an appropriate resolution and extend every effort towards its adoption.

Adopted. Reference committee recommendation that the role of the present Educational Council for Foreign Medical Graduates in supplying interns and residents for the many vacancies in our hospitals be given due consideration—Adopted (page 475)

Judicial Council

(Reference Committee "A")

DANIEL F. FEATHERSTON, M.D., Chairman, Asbury Park

The work of the Judicial Council has continued through an interesting year, in the course of which it presented some rather important opinions, which are subjoined to this report. The major problem of the judicial mechanism of The Medical Society of New Jersey continues to be the lapse of time between the filing of a complaint and its disposition by county judicial committees. We are striving—and will continue to strive—to speed these procedures, in order to deal with all complaints promptly.

From the official files of the Judicial Council, we present the following resume of the operations of the Judicial Council and of county judicial committees for the year now ending March 31, 1959.

By the Judicial Council:

Appeal Hearings Granted	3
Formal Opinions Rendered	4

1) Ethical acceptability of out-of-state clinical or bioanalytic laboratories' soliciting business from New Jersey doctors on a "package plan" basis
2) Ethical acceptability of certain classified advertisements in THE JOURNAL of The Medical Society of New Jersey (two opinions)
3) Definition of the term "association" as applicable to osteopaths

(N.B.—For the information of the membership, these four opinions are presented in full as an appendix to this report.)

By County Judicial Committees:

Complaints Reported as Disposed of	73
Complaints Still Pending	14

The Judicial Council is continuing to emphasize to all judicial committees of component county societies that it is absolutely essential for the efficiency of the operation of the judicial mechanism that Report Forms A and B be promptly submitted to the Judicial Council in conjunction with all complaints dealt with by county judicial committees. Only when such forms are regularly supplied can the Council be sure that it is cognizant of all the actions of the county judicial committees, and only then can it properly exercise its supervisory responsibility for the entire judicial mechanism.

I cannot close this report without paying tribute to my fellows of the Judicial Council for the constancy and the efficiency with which they have fulfilled their responsibilities throughout the year. The Council meets regularly each month except during July and August, and its meetings regularly consume four or five hours. As Chairman of the Council I have never heard grudging comment from any member of the Council, and I have been profoundly impressed by the unselfish loyalty which the Councilors bring to all their efforts in behalf of The Medical Society of New Jersey. I am indebted to them for their work and for their inspiration, and I wholeheartedly commend them for the approbation of this House. Likewise I commend our Legal Counsel and our Executive Officer, without whose advice and assistance it would be impossible for the Council efficiently to operate.

OUT-OF-STATE CLINICAL OR BIOANALYTIC LABORATORIES' ETHICAL ACCEPTABILITY OF SOLICITING BUSINESS FROM NEW JERSEY DOCTORS ON A "PACKAGE PLAN" BASIS

OPINION ADOPTED DECEMBER 14, 1958

Referred by the Board of Trustees to the Judicial Council for opinion was a communication from the New Jersey State Board of Medical Examiners, calling attention to the fact that "certain out-of-state clinical or bioanalytic laboratories (Kings County Research Laboratory, New York) are soliciting business from New Jersey doctors on a "package plan' basis; specifically an unlimited amount and variety of laboratory tests for a fee of $60 per month." The State Board reports that it has ruled such practice on the part of laboratories licensed in New Jersey to be "unprofessional and unethical," but it can exercise no jurisdiction over out-of-state laboratories. And it is of the opinion that this practice raises the question of "financial inducement for the obtaining of referrals equivalent to direct or indirect rebates or discounts."

In conjunction with the above, the Council directed that an official inquiry be addressed to the Kings County Medical Society, soliciting from its Judicial Committee an opinion concerning the ethical and legal acceptability of the operation of this laboratory or of any other of the same character. The Judicial Council also is interested in learning whether or not the services of the laboratory are freely utilized by the members of the Kings County Medical Society, and if so, what has been the experience of the county society as the result of such utilization.

In considering the reply from the Director of the Kings County Medical Society, the Judicial Council noted that it is reported: "The Board of Censors of the Medical Society of the County of Kings has examined into the Kings County Research Laboratory, and has decided that there is nothing unethical in doctors' who are members of the Medical Society of the County of Kings using the services of this Laboratory, providing that the physicians themselves do not make a profit on individual services which the Laboratory gives to patients . . . "

The Council concurred in this point of view.

The letter also states that "A great many of our members are using the services of the Kings County Research Laboratory, which has neither been approved nor disapproved by the Medical Society of the County of Kings."

On the basis of this report and its own investigation, the Judicial Council is of the unanimous opinion that the utilization of this service is in itself not unethical. However, it would caution member-physicians of The Medical Society of New Jersey to be certain that the services of the Kings County Research Laboratory (or of any other similar laboratory) are scientifically dependable and that the charge reflected in the patient's bill is reasonable and proportionate with relation to the cost to the physician for the services rendered.

The Judicial Council directed that this opinion be circulated among the county medical societies of the State.

ETHICAL ACCEPTABILITY OF CERTAIN CLASSFIED ADVERTISEMENTS IN THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

OPINIONS ADOPTED SEPTEMBER 28, 1958

In recent issues of The Journal there appeared the following advertisements.

Radiologist will interpret films taken in practitioners' offices. Reports telephoned immediately. Developing service, technical assistance and pickup messenger service available.

Fungus Diagnostic Services—Prompt determination of fungus disease from skin scrapings, blister tops, hair and nail clippings. Inquiries invited.

In a communication to the Board, the Editor of The Journal reports that "the Publication Committee had not objected to these classified advertisements because they represented a necessary service to patients in rural areas or in areas where the appropriate services are not available." The Editor goes on to say, "We have received a letter from the American College of Radiology protesting that such a practice is unethical in terms of their own standards. They particularly raise the issue of the billing of the patient for the service. Unless the specialist submits a separate bill to the patient the practice may be that of fee splitting or ghost assistance." The Editor requests "a ruling on whether we should accept advertisements of this type from reputable members of our Society."

In compliance with the request, the Judicial Council of The Medical Society of New Jersey observes that the Judicial Council of the American Medical Association has declared that the adoption of the new "Principles of Medical Ethics" does not in any way abrogate the Principles in force prior to 1957. The relevant section of the old code reads:

> *Chapter* 1, *Section* 4 . . . *Advertising.* Solicitation of patients, directly or indirectly, by a physician, groups of physicians, or by institutions or organizations is unethical . . .

In the March 30, 1957 issue of *The Journal of the American Medical Association,* the following opinion of the A.M.A. Judicial Council was published:

> *Unethical Advertising*: The principles of Medical Ethics do not proscribe advertising as such; they proscribe the solicitation of patients. Advertising, in its broad sense, means the act of making information, fact, or intention known to the public. Solicitation, as used in the Principles, means the attempt to obtain patients by persuasion or influence. Advertising, as distinguished from solicitation, is not in itself unethical.
>
> The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and the like. The doctor may ethically furnish this information through the accepted local mediums of advertising, which are open to all physicians on like condition. Telephone listings, office signs, professional cards, dignified announcements, all are acceptable mediums of making factual information available to the public.
>
> The particular use to be made of any ethical advertising medium and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine, what transcends advertising and becomes solicitation are questions of fact. The application of this principle is to be made locally.

In these instances there is no solicitation of the public involved, since the advertisements

are addressed only to fellow-physicians appearing as they do, in a medium intended exclusively for members of The Medical Society of New Jersey.

Therefore, in the light of the foregoing, it is the opinion of the Judicial Council of The Medical Society of New Jersey that the practice as reflected in the advertisements submitted for study does *not* violate the Principles of Medical Ethics of the American Medical Association, and in consequence, is not unethical.

However, inasmuch as this practice seems to be distasteful to representative individuals and groups of members of The Medical Society of New Jersey and in their view may tend to lead to questionable fee collection procedures, the Judicial Council recommends that the Publication Committee seriously consider the advisability of discontinuing this type of advertising.*

In a communication to the Judicial Council, the President of the New Jersey Heart Association called attention to an advertisement in the July issue of THE JOURNAL of The Medical Society of New Jersey, wherein a "cardiologist with twenty-two years' experience reading electrocardiograms" is advertising his professional services for interpretation of electrocardiograms. The President of the Heart Association goes on to say, "Such an action is highly unethical in my opinion and warrants complete investigation by the Judicial Council of the circumstances under which a member of The Medical Society of New Jersey is advertising in the official JOURNAL of the Society. Certainly the recognized cardiologists throughout the state would consider this method of soliciting patients a most unethical way to practice medicine."

The Judicial Council gave as its opinion that its findings in conjunction with the inquiry submitted by the Editor of THE JOURNAL of The Medical Society of New Jersey apply in this instance, also. The advertisement,* in the opinion of the Council, is *not* unethical, because it is not addressed to, and does not by direct or indirect means, solicit patients.

DEFINITION OF TERM "ASSOCIATION" AS APPLICABLE TO OSTEOPATHS

OPINION ADOPTED DECEMBER 14, 1958

Under date of May 2, 1958, the Board of Trustees requested that the Council consider the possibility of clarifying the opinion (December 20, 1956) in which it had declared that, under the Principles of Medical Ethics, all voluntary professional association of members of The Medical Society of New Jersey with osteopathic physicians is unethical. This request on the part of the Board was made in consequence of proposed favorable action by the Board, later abandoned, on the following: 'That the Board reaffirm its action, taken on November 24, 1946, and reaffirmed on October 25, 1953: 'Resolved, that it shall *not* be considered unethical on the part of any member of The Medical Society of New Jersey to consult with anyone who possesses a full license to practice medicine and surgery in New Jersey'."

Under date of May 16, the Judicial Council, with unanimous agreement, pointed out that under the Constitution and Bylaws of The Medical Society of New Jersey it is not proper to the Board of Trustees to pass upon the ethical aspects of any action or question confronting The Medical Society of New Jersey. At that time the Council also informed the Board that "it is willing to evolve a clearcut definition of the term 'association' so that no inequity or disservice may accrue to the members of The Medical Society of New Jersey or to the general public through the inaccurate or mistaken interpretation of the ethical canon involved."

In an attempt to arrive at this definition, the Council has carried this item on the agenda of three successive meetings. By unanimous action—based on individual poll of each Councilor—the Judicial Council presents the following official clarification, which was also concurred in by legal counsel:

> "Voluntary professional association," in the sense in which the term is employed by the Judicial Council of The Medical Society of New Jersey, may be defined as "a relationship of professional cooperation freely entered into and maintained by licensed physicians who function as professional coequals." In the case of such a relationship between a doctor of medicine and a doctor of osteopathy, the ethical violation derives from the fact that such relationship constitutes a tacit recognition on the part of the doctor of medicine of dependable scientific knowledge and competence in the doctor of osteopathy which, as a cultist, it must be assumed the doctor of osteopathy does not possess. It thus encourages confidence on the part of the public toward the doctor of osteopathy, which is not merited or justified. This type of relationship is proscribed by the Principles of Ethics of the American Medical Association, to which Principles The Medical Society of New Jersey adheres.

*This advertising has been discontinued.

However, in the view of the Judicial Council of The Medical Society of New Jersey the proscription does not extend to include an individual, emergency, professional consultative contact entered into by a fully licensed doctor of medicine with a fully licensed doctor of osteopathy, and indulged because of critical need on the part of the patient for such knowledge as the doctor of medicine can bring to bear in his behalf, and the doctor of osteopathy cannot.

As long as osteopaths continue to embrace the osteopathic concept they will persist in practicing a method *not* founded on a scientific basis, and doctors of medicine will not be free to associate professionally with them. The choice is for the American Osteopathic Association—and all its affiliates—to make. Until osteopaths formally and officially abandon the osteopathic concept, they make it impossible for doctors of medicine to work with them regularly in the care of patients.

The Judicial Council directed that as soon as this opinion has been submitted to the Board and received by it, the sequence of opinions of the Judicial Council in this connection be prepared, including this clarification and presentation, for the information of the members of The Medical Society of New Jersey. This opinion and clarification are to be given proper and adequate publicity.

Adopted (page 471)

Executive Officer

(Reference Committee "A")

Richard I. Nevin, Trenton

It is practically inevitable that the report of the Executive Officer assume the character of a twice-, or even a thrice-, told tale. For one thing, his report necessarily embodies a summarization of the activities and accomplishments of the administrative year, and every administrative year, in its fundamentals, is much like every other one which has gone before. For another thing, since the annual report of the Executive Officer should properly touch upon developments in the salient areas of the Society's operations, it is inescapable that it cite some data of information separately supplied in the reports of other officers and committee chairmen.

The one singular service which such a report can supply is to acquaint the House of Delegates and the general membership with specific observations such as are possible only for someone situated—as is the Executive Officer—so to have an inclusive and intimate knowledge of, and part in, the Society's concerns and activities year after year. In that spirit and with that intent, this report is respectfully submitted.

The year has been the most active and demanding that I have known since taking office in 1951. Medical Society business seems progressively to be involved in a spiral of expansion, intensification, and acceleration, not only in New Jersey but everywhere in the nation. Our concerns—both in the internal workings and relations of organized medicine and in external relations with other agencies of all kinds—seem to multiply with every passing year, and the tension and tempo of our duties proportionately to increase. We hope that our efforts are carrying us and our purposes forward, but as Lewis Carroll has Alice say somewhere in his narrative of her adventures, "You have to run very fast to stay in the same place here." We are giving our all to the effort of running and breathlessly praying for a strengthening second wind.

The scope and sweep of the tide of the Society's activities are dispassionately reflected in a few significant statistics. For example, last year I reported that in the Executive Offices we dealt with in excess of 190,000 pieces of mail (incoming and outgoing). This year, our volume is hovering around the quarter of a million mark! From June of 1958 to March of 1959, eighty-seven meetings dealing with the Society's business were held in the Headquarters building, not to count others held in other places for reasons of convenience.

For my part, in the course of the administrative year—over and above carrying on my regular official duties as chief of staff—I have attended and participated in approximately 180 meetings or conferences, made eight trips out of state on the business of the Society, and filled fifteen speaking engagements.

The president and all the other officers of the Society have been similarly busily en-

gaged. It is to their credit—and to the solace and satisfaction of the entire Society—that each new challenge is met head-on and vigorously dealt with, in a heartening spirit of "all for one and one for all."

It would be as unfair as it would be difficult to single out any committee or other official agency of the Society as meriting special commendation. If accolades are in order, in my opinion they should be given to all who have this year actively and wholeheartedly served medicine and the people of New Jersey.

Many old problems remain to be dealt with, and new ones are constantly presenting themselves, but we are working together—with heart and head—realistically to analyze and to solve them. With encouragement and increasing support and assistance from the entire membership, we may yet accomplish prodigies of attainment. Certainly if we do not, it will not be because we have not valiantly tried.

Adopted (page 471)

STANDING COMMITTEES

Finance and Budget

(Reference Committee "B")

David B. Allman, M.D., Chairman, Atlantic City

A review of the expenses and accounts to date indicates that the individual accounts are sound and that a favorable balance in the total budget can be anticipated.

JOURNAL

The Publication Committee is commended for its continued excellent financial status. Again, no budget appropriation has been requested for the publication of The Journal, Journal office expenses, and travel. The Publication Committee will continue to operate on its advertising income.

AMERICAN MEDICAL EDUCATION FOUNDATION

It is the opinion of your committee that the contribution to A.M.E.F. should not be part of the annual budget, that the House of Delegates should set the level of contribution on a per capita basis, that this per capita levy should be in addition to the budgetary assessment, and that both the A.M.E.F. assessment and the budgetary assessment should be paid at the same time. The Board of Trustees concurs in this opinion.

From the current assessment $10,000 has been set aside in a reserve account for the 1959 contribution to A.M.E.F. If the House of Delegates approves the committee's recommendation concerning A.M.E.F., that portion of the 1960 assessment to be allocated as an A.M.E.F. contribution will be credited to a special account upon receipt of the 1960 assessment next year. At such time as the 1960 A.M.E.F. contribution is to be made the total of the special account will be withdrawn in one check and presented to the A.M.E.F.

In following this procedure the Finance and Budget Committee can maintain the budget on an equalized basis during the fiscal year without having the disturbing influence of a large calendar year contribution.

1959 ASSESSMENT

The computation of cash surplus for the close of the current fiscal year is estimated at slightly above $100,000—which sum has been indicated as the desired surplus amount at the beginning of each new fiscal year. In this computation there is a reserve of $10,000 for the 1959 contribution to A.M.E.F., and in accordance with the action of the Board of Trustees, at its January meeting—"that for this year the interest income from investments be paid into the Medical Student Loan Fund."—the interest from investments has also been set aside in a reserve account. Making no provision in the proposed budget for a contribution to A.M.E.F., the actual budgetary requirement is $34.60 per capita. Your com-

mittee is of the opinion that the 1960 assessment should be $35 per capita.

BUDGET FOR 1959-1960

Below is a copy of the proposed budget for 1959-60 which has the approval of the Board of Trustees. One new account has been added —E-6, Medical Student Loan Fund; in accordance with the action of the Board of Trustees, at its January meeting, "that $5,000 each year be appropriated to maintain the Medical Student Loan Fund," this new account in the amount of $5,000 has been added to the budget.

RECOMMENDATIONS

1. A.M.E.F.

   a). That the 1959 contribution to A.M.E.F. be in the amount of $10,000, payable from the reserve account set aside for this purpose from the 1959 assessments.

Adopted (page 472)

   b). That the per capita level of contribution to A.M.E.F. for 1960 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Reference committee recommendation that a per capita contribution of $5.00 is not unreasonable—Adopted (page 472)

2. 1960 Per Capita Assessment
   That the 1960 assessment be adopted at $35 per capita with no provisions for contribution to A.M.E.F.

Adopted (page 472)

3. Budget for 1959-1960
   That the budget for 1959-1960 be adopted in the sum of $183,813.

Adopted (page 472)

PROPOSED BUDGET FOR 1959-1960

A-1	Executive Salaries	$43,320.00
A-2	Executive Office Salaries	42,919.00
A-3	Executive Office Expenses	1,700.00
A-4	Executive Travel	2,400.00
A-5	House Maintenance	13,667.00
A-6	Treasurer	2,930.00
A-7	Finance and Budget Committee	100.00
A-8	Secretary	1,320.00
A-9	Salary Taxes	2,120.00
A-10	Insurance	2,215.00
C-1	Welfare Committee	800.00
C-2	Legislative Committee	7,500.00
C-3	Public Health Committee	1,700.00
C-4	Public Relations Committee	9,050.00
C-5	Medical Practice Committee	1,100.00
D-1	President and Presidential Officers	4,620.00
D-2	A.M.A. Delegates	8,440.00
D-3	Woman's Auxiliary	8,662.00
D-4	Medical Education Committee	100.00
D-5	Liaison Committees	300.00
D-6	Directory, Membership, Physicians Placement	5,000.00
D-7	Civil Defense-Diaster Control Committee	100.00
D-9	Archives and History	100.00
D-10	Blood Bank Commission	250.00
D-11	Medical Defense and Insurance Committee	750.00
E-1	Board of Trustees	4,000.00
E-2	Contingent	5,000.00
E-3	Judicial Council	2,250.00
E-4	Legal	6,300.00
E-6	Medical Student Loan Fund	5,000.00
	TOTAL	$183,813.00

Adopted (page 472)

Honorary Membership

(Reference Committee on Resolutions and Memorials)

ALDRICH C. CROWE, M.D., Chairman, Ocean City

No names have been submitted for Honorary Membership in The Medical Society of New Jersey. Therefore, it has not been necessary for the committee to meet this year.

Adopted (page 477)

Publication

(Reference Committee "B")

Fred B. Rogers, M.D., Chairman, Trenton

One of our 1958 highlights has been the extent to which Dr. Davidson's editorials have been reprinted elsewhere. His "Brand Name Drugs" in the January issue was reprinted in 13 other periodicals and has been distributed to students in several medical schools. "Man's Oldest Food" in the June issue became the guest editorial of the month in *Clinical Medicine. The Journal of the Indiana State Medical Association* reprinted "Sticking Your Neck Out" from our July JOURNAL. *The Pennsylvania Medical Journal* and several local newspapers reprinted "Mike and Ike Can Look Alike" in the August issue. In the same issue, Dr. Davidson's editorial entitled "Coffee Break" really made a hit. We found it reprinted in 7 newspapers from Washington to Detroit, and—needless to say—the coffee industry sent us fan mail. Both the September editorials were in demand. The *Virginia Medical Monthly* reproduced "The Quiet Side of Blue Shield" and *Current Medical Digest* not only reprinted "Psychosomatic Dilemma" but sent us a batch of fan mail that their reprinting brought in to Baltimore.

Both October editorials also hit the jackpot. "The Rod of Comfort" was picked up in Texas and the *A.M.A. Journal* reprinted "Animal Kingdom." Three pharmaceutical journals and three newspapers reprinted "The Man Behind the Medicines" from our November JOURNAL. In the same issue, "One Big Health Agency" was reproduced both in the *Sight Saving Review* and in the *Pennsylvania Medical Journal*. And from our December issue, West Virginia reprinted "No More Hysteria"—altogether, an amazing record! I doubt if any medical journal in the country can point to such an accolade.

In July 1958 we increased our advertising rates by 10 per cent. This was our first increase in 4½ years. We held the line here longer than most state medical journals. In spite of this we printed more pages of advertising (952 compared with 930) than in 1957. The amount of space devoted to State Activities also went up: 240 pages compared with 116 last year. An increasing interest in the cultural heritage of the Society was again reflected in letters to THE JOURNAL and a series of well-received historical articles. In general the 1958 space scoreboard was:

291	pages of Original Scientific Articles
41	pages of Historical Articles
240	pages of State Activities
32	pages of Editorials
2	pages of our new feature "Marginalia of Medicine"
16	pages of Announcements
1	page of Woman's Auxiliary material
1	page of "Letters to THE JOURNAL"
29	pages of County Society Reports
19	pages of Book Reviews
672	pages of text (compared with 592 last year)
952	pages of advertising (last year: 930)
1624	pages total (compared with 1522 last year)
132	pages of advertising inserts
1756	pages: grand total

In 1958 for the first time, the Transactions of a full Annual Meeting were part of THE JOURNAL and not a supplement. This saved the Medical Society about $2,000, since the cost of this material in THE JOURNAL was absorbed by THE JOURNAL and was paid for by advertising income. Also THE JOURNAL is now running additional items which were formerly issued in the Transactions supplement. This innovation has not only reduced expense but has made it possible to include all the Society's activities in a uniformly bound and indexed set of JOURNALS.

For the fourth consecutive year, the committee makes no request for funds for publication of THE JOURNAL. We expect to operate the periodical on our excess of advertising income over publication costs.

Adopted (page 472)

Medical Defense and Insurance

(Reference Committee "D")

J. Wallace Hurff, M.D., Chairman, Newark

PROFESSIONAL LIABILITY INSURANCE

The year 1958 has introduced several new problems in relation to professional liability. Prior to May 1958, when the immunity against civil suit was lifted from hospitals by the State Supreme Court, your committee's problems were chiefly centered about the medical liability of individuals. Now, however, this is complicated by the need for legal interpretations or lines of demarcation between the physicians and the hospital as to respective liability and responsibility.

For clarification, when a patient enters a hospital there now exists dual responsibility: that of the hospital which provides the facilities and the materials with which the doctor renders his medical service; and that of the physicians rendering service. The problem of dividing that responsibility will reach serious proportions within a short time. The committee approaches this problem with the desire to retain the cordial and confidential relationship which hitherto has existed between the hospital and the medical staff.

Your committee now has under study the availability of hospital records and the agency relationship with the hospital, nurse, and doctor. Hospital charts may be impounded by the institution, making it difficult for the doctor to secure access to them, particularly where there is a conflict of interest.

We present these problems with the thought that they will demonstrate the complexity and the difficulties that can arise as the result of this change in liability.

The general picture of professional liability during 1958 shows a marked increase in the number of claims reported, approximately 100 per cent increase over that of 1952, as demonstrated by the tabulation below:

Year	Claims Reported
1950	93
1951	89
1952	105
1953	103
1954	95
1955	126
1956	126
1957	164
1958	210

Correspondingly, the claim data during the same period indicate approximately a 200 per cent increase in claims evaluation. The total amount of damages sought in suits currently pending is in excess of $20,000,000. We estimate that one in 21 physicians insured reported a claim in 1958.

An analysis of 151 of the 210 cases reported during 1958, indicates that doctors are more vulnerable to professional liability claims during their more active years of practice. These cases represent approximately 72 per cent of the claims reported to the United States Fidelity and Guaranty Company, and probably not representing more than 50 per cent of the total of the claims reported in the State. We hope to have additional data available before the annual meeting.

A further analysis of this information by the specialty of the physicians reporting claims develops the following:

SPECIALTY OF 138 PHYSICIANS REPORTING CLAIMS

Claims	Specialty
33	General practice
20	General surgery
17	Obstetrics and gynecology
13	Internal medicine
9	Orthopedic surgery
7	Pediatrics
6	Anesthesiology
6	Psychiatry and neurology
5	Eye, ear, nose, throat
4	Radiology and roentgenology
3	Dermatology
3	Traumatic surgery
3	Otolaryngology
3	Neurosurgery
2	Urology
2	Plastic surgery
2	Ophthalmology

Professional liability claims thus affect all branches of practice. However, as noted above, 70 per cent of the claims were against specialists.

We call your attention to the vulnerability of the surgical specialties. These accounted for 72 of the claims (general surgery, obstetrics, gynecology, orthopedics, anesthesiology, ophthalmology, otology, laryngology, neurosugery, traumatic surgery, urologly and plastic surgery) or 51 per cent of all claims filed last year. This does not mean that surgery as a science is not advancing, but rather that, due to the

advancement of surgical science, the profession is accepting the challenge of applying surgical skills in hazardous or dangerous cases in which they never attempted a few years ago.

A few remarks should be in order in relation to specific points of vulnerability. First, the admitting diagnosis. Unless a doctor is absolutely positive, his admitting diagnosis should be preceded by the word "possible" or probable." It is the final diagnosis that will be accepted by the Blue Cross wherever this procedure is followed.

Second, we call to your attention the use of antibiotics. There have been instances in which a jury has interpreted the dosage used as in excess of that recommended in standard reference books. It is common practice in serious infections to exceed the recommended dosage. The physician would be wise to protect himself by consultation when so doing.

All too frequently when suits arise, a doctor who thinks almost entirely from a scientific basis finds that his records lack the completely detailed information necessary to protect his interests. Your committee cannot emphasize too strongly the physician's personal responsibility to himself to scrutinize his records and ascertain that they are detailed and in perfect order.

In spite of repeated appeals, some physicians are inadequately covered. We have had specific instances which demonstrate that physicians have suffered great financial losses because of this. We cannot emphasize too strongly that ample liability coverage is the only thing that stands between the actively practicing physician and possible financial ruin.

Last year we expressed the opinion that every physician should protect his interests by a basic $50 to $150,000 limit; now one year later, we would recommend that you double this amount if possible.

Very frequently members of your committee are asked by practicing physicians in New Jersey, "What are the advantages of my being insured under the State program?" Your committee recognizes that it is the right of each individual to secure liability protection on a voluntary basis. We are aware of the fact that some members have their liability coverage under some of the specialty groups. That is their prerogative and their right.

As a committee we are unanimous in our opinion that, on a voluntary basis and on a loyalty basis, it is to your best interest to secure your liability coverage through our State plan. We say this for the following reasons: liability in all its phases is influenced or controlled by laws of New Jersey, interpreted by the Courts of New Jersey, and judged by the people of this State. Moreover, since the hospitals have been brought into this picture, hereto, any constructive efforts of approach will be on a State basis.

We maintain as a committee that coverage in specialty groups should supplement our basic liability coverage. We also emphatically hold to the opinion that our greatest efficiency in the conduct of the work of this committee can be only through a central agency, with the support and mutual understanding of every member of our Society.

The committee is deeply conscious of its inability to reach each and every physician and knows that there is much of this problem that should be discussed in full in executive meetings.

It is with deep regret that your committee announces the loss of Dr. Andrew Ruoff of Hudson County as a member of this committee. Dr. Ruoff's contribution to this work was of inestimable value to the committee and to The Medical Society of New Jersey as a whole. His passing leaves a void of which we will be conscious for many years to come. We mourn his loss.

RECOMMENDATION

Your committee is unanimous in its endorsement that we continue the services of Faulhaber & Heard, Inc., as our broker for professional liability coverage. This firm has been, for many years, of inestimable value to the committee.

ACCIDENT AND HEALTH INSURANCE

The Committee on Medical Defense and Insurance is very happy to report expansions in insurance benefits for members of the Society. In answer to a growing demand for a low cost life insurance plan, your committee has developed for members of the Society a life insurance plan which the Board of Trustees has approved. Descriptive brochures of the life plan, containing application forms, have already been mailed to the eligible members of our Society.

The plan is a Five Year Renewable and Convertible Term Policy available to all members in active practice and under the age of 65. Immediately upon receipt and approval of a simple application, $10,000 policies will be issued promptly to acceptable risks who are in active practice and under the age 65. When 30 per cent of the membership apply during the enrollment period, $10,000 policies will be issued to the impaired risks who are in active

practice and under the age of 65. After the initial issue of a $10,000 policy to the acceptable risk, additional units up to $40,000 will be made available under this plan at the same rates, subject to the insurance company's approval of requests for the additional units. The plan will be administered by E. & W. Blanksteen Agency, Inc. of Jersey City who developed this plan for us and whose affiliate, E. & W. Blanksteen, have administered our accident and health insurance plan of the National Casualty Company for the past 26 years.

During the past year, the Blanksteen Agency started work on the additional plan of accident and health insurance in the Nationwide Mutual Insurance Company—a plan approved at the 1958 Annual Meeting. Approximately 300 of our members have applied for this additional plan of accident and health insurance; it is gaining momentum as time goes on. A concentrated enrollment campaign for the additional plan of accident and health insurance will be conducted by the agency after the current life insurance enrollment has been completed.

Under our basic accident and health insurance plan with the National Casualty Company, we are happy to report an all time high of membership participation. As of March 1, 1959, 3700 of our members held accident and health policies under this original plan. During the past year, 416 claims for disability were paid to our members with the highest amount paid to any individual totalling $7,705. In 1956, we installed the extended coverage policy of the National Casualty Company. This policy provides sickness coverage for another five years after the two-year sickness benefits are exhausted under the basic policy, and accident benefits for lifetime after the first five years are exhausted under the basic policy. At the present time, two of our members are collecting benefits under the extended coverage.

All disability claims presented under our Society's program were handled by the company and the agency promptly and with dispatch, and another year has passed during which no claim resulted in a dispute which had to be referred to the Committee on Medical Defense and Insurance for arbitration.

The Committee on Medical Defense and Insurance is proud of its disability insurance program which now provides up to $1000 per month of disability coverage—$600 monthly benefit in the National Casualty Company and $400 monthly benefit in the Nationwide Mutual Insurance Company, in accordance with company underwriting rules and regulations —and of its life insurance program underwritten by the Nationwide Life Insurance Company of Columbus, Ohio, now being installed.

RECOMMENDATION

Your committee is unanimous in its endorsement that we continue the services of E. and W. Blanksteen as our official broker for accident and health coverage. This firm has been, for many years, of inestimable value to the committee.

Adopted (page 475)

Supplemental Report

PROFESSIONAL LIABILITY REPORT

A study of the exhibit shown below presents a tremendous increase in the number of professional liability claims on a yearly basis, County by County. To wit, Essex County with 27 claims in 1949 has increased to 53 claims in 1958; and Union County with 10 claims in 1949 has increased to 25 claims in 1958. Does one have to read further to appreciate the gravity of our liability problem as it exists today?

We call to your attention that for the 12-month period ending December 31, 1958, 19 counties reported claims, 2 counties no claims, totaling 209 claims for the period.

Comparing this period with the 12 month period from January 1, 1957 to December 31, 1957, 12 counties reported an increase in the number of claims, 4 counties reported a decrease in the number of claims, and 5 counties reported no change.

During the term of 9 years and 10 months from March 1, 1949 to December 31, 1958, all counties reported one or more claims and a total of 1,190 claims were reported.

Adopted (page 475)

9 YEARS-10 MONTH PERIOD FROM MARCH 1, 1949 TO DECEMBER 31, 1958

	12 Month Period from March 1 to March 1							10 Mo. 3/1/56 to 12/31/56			9 Years 10 Mos.	Increase or Decrease 1958 Compared to 1957
	1949	1950	1951	1952	1953	1954	1955		1957	1958		
Atlantic	1	3	—	1	1	3	4	5	8	5	31	— 3
Bergen	6	4	4	13	10	12	10	12	16	20	107	+ 4
Burlington	—	—	—	—	—	—	2	1	—	1	4	+ 1
Camden	1	1	2	1	—	4	8	1	2	11	31	+ 9
Cape May	—	—	—	—	—	—	1	—	1	1	3	—
Cumberland	—	2	1	2	—	1	—	—	1	1	8	—
Essex	27	28	29	31	28	21	24	31	43	53	315	+10
Gloucester	—	—	1	2	—	—	—	1	2	3	9	+ 1
Hudson	20	12	15	19	11	13	21	9	13	18	151	+ 5
Hunterdon	—	—	—	2	1	—	—	1	2	2	8	—
Mercer	3	7	6	2	3	7	11	2	6	7	54	+ 1
Middlesex	4	6	4	8	9	2	8	6	14	13	74	— 1
Monmouth	11	6	3	5	7	5	7	13	12	21	90	+ 9
Morris	2	2	2	1	3	1	4	1	3	4	23	+ 1
Ocean	3	—	1	1	2	4	—	2	3	1	17	— 2
Passaic	12	16	12	8	12	13	12	10	16	16	127	—
Salem	—	2	3	—	—	—	1	1	—	—	7	—
Somerset	—	—	—	4	5	1	—	1	1	4	16	+ 3
Sussex	1	2	—	—	—	—	—	1	—	3	7	+ 3
Union	10	2	6	5	9	7	11	10	19	25	104	+ 6
Warren	—	—	—	—	1	1	1	—	1	—	4	— 1
	101	93	89	105	102	95	125	108	163	209	1190	

Addition to Supplemental Report

PROFESSIONAL LIABILITY INSURANCE

It is becoming more and more evident to your committee that medical liability in itself cannot be written successfully by any insurance company. This is evident by the experience of many of the national medical groups and the unsatisfactory loss experience of our insurance carrier in New Jersey.

Our problem is simple, in that the only way that professional liability coverage can be made available to the medical profession is by supporting this protection with other forms of profitable insurance, thereby assisting the company in offsetting the loss incurred in the medical liability field.

Facing these facts it, therefore, becomes necessary that we request our representative on his contact with the physician, to secure supplemental coverages which will, to some extent, defray the losses now evident in medical liability.

The information that your committee now has is such that our failure to comply with this request may well mean loss of individual liability coverage. We are aware of the complications that may result from this request, but we are also conscious of the fact that there will be no liability coverage available unless a program of this type is accepted by the individual physicians in the State.

Disapproved. Board of Trustees assured reference committee matter would be under study on April 28, and coercive tenor in recommendation is not a way of solving the problem of liability coverage —Adopted (page 475)

Medical Education

(Reference Committee "D")

Sherman Garrison, Jr., M.D., Chairman, Bridgeton

Last year the Medical Education Committee felt that in view of the widely differing requirements for medical education programs throughout the State, these could be most advantageously organized at the county or local hospital level. The Medical Education Committee offered to cooperate with any hospital or county society in arranging a program, and recommended that a library of information of medical films, kinescopes, and audio-digest titles be maintained at the headquarters of the Medical Society in Trenton.

The committee recognizes the excellent programs organized during the past year by Rutgers University, and by Seton Hall Medical College, and their contributions to medical education throughout the State.

The committee suggests that a review of advances in diagnostic and clinical problems in each of the specialties be considered by the sections for a place on the program at the annual meeting, directed toward the goal of keeping the general practitioner up to date on new thinking in each of the specialties, and confined to a very brief report of what is actually new and important in each of the specialty fields.

Adopted (page 475)

Advisory to the Woman's Auxiliary

(Reference Committee on Miscellaneous Business)

Lewis C. Fritts, M.D., Chairman, Somerville

It is the function of this committee to evaluate, coordinate, and guide the Woman's Auxiliary to The Medical Society of New Jersey in all its interests and activities, subject to the approval of the Board of Trustees of The Medical Society of New Jersey.

To carry out its duties, this committee must have the understanding and cooperation of the officers of the Auxiliary, on the one hand, and of the members of the Board of Trustees, on the other. And your committee has certainly enjoyed the necessary bilateral understanding and cooperation and has therefore been able to carry out its function with a minimum of friction and delay. For this circumstance we are grateful to the officers of both groups.

Following the pattern adopted in preceding years, early in the new administrative year the President of the Auxiliary, Mrs. A. Guy Campo, presented the proposed program of the Auxiliary for 1958-59. Consequently, at its meeting on June 15, 1958, the Board of Trustees were able to clear the approved program, thus affording the Auxiliary ample time to develop and carry out its operations. It is our hope that this procedure of early presentation and clearance of official Auxiliary programs will be adhered to in the interest of the efficiency and effectiveness of the Auxiliary's activities.

It was a busy and successful year for the Auxiliary. All its own continuing programs were advanced, and in the field of public relations and legislation the Auxiliary continued its effective cooperation in and support of programs of the Medical Society.

The annual Workshop Conference in September marked a new high in teamwork and cooperation, in that nine representatives of The Medical Society of New Jersey participated in the program. In view of the success of that conference, it is to be hoped that similar plans will be followed in succeeding years, to insure the continuance of the rapport which all agreed this year's conference achieved.

Your committee is grateful for the generous and understanding cooperation which throughout the year it has enjoyed. The year now closing has been a satisfactory and successful one, and one, we feel, replete with advantages to both The Medical Society of New Jersey and its Woman's Auxiliary.

Adopted (page 477)

Annual Meeting

(Reference Committee on Miscellaneous Business)

Jerome G. Kaufman, M.D., Chairman, Newark

In cooperation with the President, the Section Officers, and the Chairmen of the Scientific Exhibit and the Scientific Program Committees, we believe we have arranged a program for the 1959 annual meeting that will appeal to the majority of the membership. We earnestly urge all members to attend the annual meeting and to participate in the program.

Through the cooperation of Smith Kline and French Laboratories, a motion picture program has been arranged. Appreciation is hereby expressed to the company for this valuable addition to our annual meeting program.

The exhibits—educational, scientific, and technical—were all over-subscribed this year. Because of lack of space we were unable to accept all applications. However, the exhibits to be presented will contain much information of value, and we urge those in attendance at the annual meeting to visit them.

Because of the heavy convention schedule each spring in Atlantic City, it has been advisable to set meeting dates at least four years in advance in order to secure desirable dates and hotel accommodations. The House of Delegates has already approved the following convention dates, which have been confirmed with Haddon Hall:

1960—Saturday, May 14—Wednesday, May 18
1961—Saturday, May 13—Wednesday, May 17
1962—Saturday, May 12—Wednesday, May 16

The committee presents the following recommendation concerning the annual meeting for 1963:

RECOMMENDATION

That the 197th Annual Meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City, beginning Saturday, May 11, through Wednesday, May 15, 1963.

Adopted. Reference committee recommendation that feasibility of opening technical exhibits to delegates on Sunday afternoon—Adopted (page 477)

Scientific Exhibit

(Reference Committee on Miscellaneous Business)

Thomas K. Rathmell, M.D., Chairman, Trenton

The committee mailed application forms to all hospitals, pathologists, and regional medical schools, requesting scientific exhibits for the current year. A deadline for receipt of applications was established as of January 1, 1959. To date, 29 scientific exhibits have been planned. A medical motion picture theatre will be in operation through the courtesy and cooperation of Smith Kline and French Laboratories.

Exhibits will be on the lobby floor of Haddon Hall. This is an innovation. As the result of this new location, members will have a better opportunity to view the scientific exhibits than in the past. It is anticipated that the location of the scientific exhibits on the lobby floor in 1960 may be hampered by space conflicts with other conventions. It would be well, therefore, if the membership would advise the committee as to the desirability of retention of the new exhibit area.

The work of the committee has been facilitated by the expert advice of the chairman of the Annual Meeting Committee and by the assistance of the Convention Manager.

Adopted (page 477)

Scientific Program

(Reference Committee on Miscellaneous Business)

Edward E. Seidmon, M.D., Chairman, Plainfield

Early last fall, the scientific program for the 1959 Annual Meeting was organized at a meeting with the section officers. The Sections on Orthopedic Surgery, Neuropsychiatry, and Preventive Medicine will not meet this year.

Speakers listed for the Scientific Program include 27 guest speakers, and 40 member speakers. The Annual Meeting is a "medical forum," and all sections were urged to make their programs attractive to the general membership.

The section officers were most cooperative in submitting their programs in time for the advance announcement of the annual meeting in February, and the speakers also have been cooperative in submitting abstracts of their talks for publication in the final program and in providing necessary information dealing with the presentation of their papers so that all equipment and facilities required could be made available.

We believe the scientific program will be outstanding, and we hope members will attend the sessions.

Adopted (page 477)

Welfare

(Reference Committee "E")

Jesse McCall, M.D., Chairman, Newton

The Welfare Committee met twice during the current year and regrets to report that the attendance at both meetings was disappointing—47 per cent at the first meeting, with four counties not represented; and 36 per cent at the second meeting, with six counties not represented.

The Welfare Committee considered the reports of its two special committees and of its four subcommittees. The activities of these committees are described in their individual reports. Not all recommendations of these committees were endorsed by the Welfare Committee. Several, after review and consideration, were returned for future study and clarification. However, the majority of the reports of the special and subcommittees received the approval of the Welfare Committee and, later, approval of the Board of Trustees.

It is regrettable that there is so little interest in the meetings of the Welfare Committee, as evidenced by the poor attendance, since the Welfare Committee constitutes the one opportunity—between sessions of the House of Delegates—for representatives of all component societies to be heard on matters of importance to The Medical Society of New Jersey, and points up again, the possible need for a revision of the committee structure for the Society.

Adopted (page 476)

Cancer Control

(Reference Committee "E")

Asher Yaguda, M.D., Chairman, Newark

During the past year, the committee undertook to study two major projects. The first was the desirability of establishing a cancer registry to which cancer registries in the various hospitals throughout the State would report cases of cancer and the results of treatment. In New Jersey there are now over 18 hospitals which have cancer registries in operation. The committee believes that efforts should be made to have a cancer registry started soon in every hospital in the state. The Cancer Committee working with the Cancer Division of the State Department of Health will try to establish a statewide registry in the near future. There are indications that, within a few years, cancer registries will be mandatory for a hospital to receive accreditation for intern training.

The second project was a study of radiologic hazards. A subcommittee of the Cancer Committee has met with representatives of major industries and with members of the dental and veterinary professions to discuss radiologic hazards in their fields. The study is not as yet completed. A supplemental report will be made concerning recommendations resulting from this study. One of the objectives of this study will be to present our recommendations and findings to the Governor's council for the study of radiologic hazards and to try to guide them in the medical aspects of this problem.

RECOMMENDATION

That efforts be made to have a cancer registry initiated in every hospital in the state; that the Cancer Committee working with the Cancer Division of the State Department of Health attempt to establish a statewide registry in the near future.

Adopted (page 476)

Supplemental Report

RADIOLOGIC HAZARDS

In order to reduce the radiologic exposure to citizens of the State of New Jersey, the following recommendations are submitted by the Subcommittee on Radiologic Hazards of the Special Committee on Cancer Control:

I. INDUSTRIAL HAZARDS

A. *Radioisotopes*

Since radioactive isotopes have been controlled by the Atomic Energy Commission, no additional recommendations are required. It is felt that radioisotopes not controlled by the Atomic Energy Commission, such as radium and cyclotron-produced isotopes, should be handled under the same regulations as those that are affected by the Atomic Energy Commission, with the same precautions being observed.

B. *X-ray for Welding, Examination of Parts, Quality Control*

1. All personnel in the area of radiation should wear film badges and/or pocket dosimeters on that part of the body that will be maximally irradiated. A log should be kept of each worker's exposure.
2. Each piece of x-ray equipment should be monitored by a competent person at regular intervals and a log kept of the findings.
3. All personnel who work with radiation should be educated about the hazards therein.

II. MEDICAL HAZARDS

This committee feels that diagnostic x-ray technics have been of major importance in maintaining health and in increasing the life span in our society. They have been of great value in the detection of disease. It is not our

purpose to dissuade physicians and patients from these necessary procedures but, rather, to make recommendations so that these procedures may be carried out with a minimum of radiologic hazard.

A. *Fluoroscopy*

(a) Equipment and Procedures

1. At the table top, the output of the machine should be 5 r/min. or less.
2. Each machine should have a minimum filtration of 2 mm. of Al., which gives a h.v.l. between 2 and 4.5 mm. of Al.
3. Each field should be centered such that the center ray goes through the center of the screen. The shutter system should be so adjusted that with a maximum field there is approximately an inch of unirradiated screen. It is recommended that a slotted, hanging, lead rubber apron be attached to the appropriate portion of the fluoroscopic screen.
4. Each machine should be monitored to check the output, the h.v.l. and the stray radiation when installed and when any change is made in the equipment.
5. All machines should have a limiting timer attached to them.
6. It is recommended that as small a field size as possible be used.

(b) Personnel

1. Adequate time should be allowed for dark adapting.
2. Aprons of adequate length and with a minimum thickness of .2 mm of lead should be mandatory.
3. All personnel who are repeatedly exposed to radiation should be monitored by film badges and/or pocket dosimeters and a permanent log kept.
4. Education for radiologic protection should be carried out periodically.

B. *Radiography*

(a) Equipment and Procedures

1. There should be a filter in the beam of not less than 1 mm. of Al.
2. Cones should have an aperture as small as possible to just cover the film used at the required distance.
3. X-rays should be taken utilizing a technic that minimizes exposure to all areas that are not being examined, with particular attention to minimizing gonadal exposure.
4. Whenever the gonads may be exposed in the course of examining an adjacent area, it is recommended that a lead shield or lead rubber apron be used for additional protection.

(b) Personnel

1. The personnel should stay behind adequate protective barriers during each exposure.
2. When patients must be held or assisted, it is recommended that whenever possible different personnel, particularly non-hospital personnel, perform this service. All such personnel should wear protective aprons and gloves and stand as far out of the beam as possible.

C. *Radiation Therapy*

1. Each installation should be calibrated for output and h.v.l. at least once per year. The area should be monitored for scatter radiation.
2. All personnel in the radiation area should be monitored by film badges.
3. Wherever possible, the patient should be so positioned that the gonads are as great a distance as possible from the direct beam. Shielding should be used if necessary.

III. DENTAL HAZARDS

A. *Equipment and Procedures*

1. The beam should be filtered with 1 to 2 mm. of Al. giving a beam of an h.v.l. of 1 to 2 mm. of Al.
2. A lead slug one mm. thick with an aperture just sufficient to allow the primary beam to cover the dental film should be used as a limiting diaphragm.
3. Film should be held by film holders in the mouth, never by either the patient's or the dentist's fingers.
4. The beam should be directed so that the radiation to other areas of the patient is minimized.
5. Wherever possible, fast film with the appropriate timer should be employed.

B. *Dental Personnel*

1. The dentist should stay outside the primary beam at all times.
2. Wherever possible, the exposure switch should be outside the patient area behind a plaster wall or lead screen.
3. All personnel regularly exposed to radiation should be monitored by film badges and/or pocket dosimeters.

IV. VETERINARY HAZARDS

Since fluoroscopy in veterinary medicine is only rarely necessary and since its hazards are great, it is recommended that radiography be used whenever possible in veterinary medicine.

A. *Radiography Equipment and Procedures*

1. There should be a filter in the beam of not less than 1 mm. of Al.
2. Cones should have an aperture as small as possible to just cover the film used at the required distance.
3. X-rays should be taken utilizing a technic that minimizes exposure to all areas that are not being examined, with particular attention to minimizing gonadal exposure.
4. Whenever the gonads may be exposed in the course of examining an adjacent area, it is recommended that a lead shield or lead rubber apron be used for additional protection.

A. *Veterinary Personnel*

1. The personnel should stay behind protective lead barriers during exposure.
2. When animals must be held or assisted, it is recommended that whenever possible different personnel, particularly non-hospital personnel, perform this service. All such personnel should wear protective aprons and gloves and stand as far out of the beam as possible.

Adopted. Recommendation of reference committee that this report be made available to all practicing physicians in New Jersey—Adopted (page 476)

This subcommittee, after interviewing many individuals who use radiation in industry, medicine, veterinary medicine and dentistry, and after discussing methods most effective to reduce unnecessary radiation, has been impressed with the great need to educate all personnel who work with radiation about the hazards and methods for reducing these hazards.

No matter how specifically the regulations are written or how carefully machines are calibrated, unless the individuals working in a radiation area have an understanding of the basic problems of radiologic safety, needless and damaging exposures will occur.

Maternal and Infant Welfare

(Reference Committee "E")

John D. Preece, M.D., Chairman, Trenton

The Committee on Maternal and Infant Welfare has had a very satisfying year. The work of collecting and classifying maternal deaths is facilitated by the increasing efficiency of our field physicians, who work under the guidance of the New Jersey Department of Maternal and Child Health.

Our annual meeting this year was up to its usual high standard. This committee is one of the largest in the Society. We continue to have requests each year for additional new members. One of the present members recommended another obstetrician for membership, but added that the recommendation did not hold if it meant sacrificing personal membership.

In line with this enthusiasm for sharing the advantages of the meeting with others in the Society, the committee feels that secretarial assistance should be provided for the meetings of the Committee on Maternal and Infant Welfare to record the proceedings. From the cases reported and the discussions thereon by the committee, a selection would be made for their educational value to be published in The Journal of The Medical Society of New Jersey.

Adopted (page 476)

SUBCOMMITTEES OF THE WELFARE COMMITTEE

Legislation

(Reference Committee "E")

C. Byron Blaisdell, M.D., Chairman, Asbury Park
H. Hale Hollingsworth, M.D., Co-Chairman, Clifton

This committee submits at this time what is necessarily a preliminary report, due to the early date of the annual meeting and the fact that at the time of this writing the Board of Trustees has not passed on the recommendations of the Welfare Committee. A busy legislature has already, as of March 27, introduced 656 Assembly and 221 Senate resolutions and bills; by the close of the meeting scheduled for April 8, this committee will have reviewed and recommended positions on all which relate to medicine and public health.

January's *Membership News Letter* reported the Society's positions on all such legislation to the end of the 1958 session, including active opposition to three measures (A-178, A-253, A-281); approval of fourteen, and of two others in principle or purpose; and disapproval of eleven others. Each year finds certain bills dealing with the same subjects—licensing and examination of drunken drivers, licensing of physiotherapists, licensing of electrologists, presuming service-connected disabilities for police and firemen, the sale of non-prescription drugs, and extension of the scope of practice of paramedical groups.

STATE LEGISLATION

In the current session your subcommittee has reviewed all bills submitted by the Legislative Analyst and the Executive Officer for its consideration. Many are the same as those so well summarized in January's *Membership News Letter*.

The Medical Society's own bill, S-147, to make the report of an examination of a school child by a licensed physician of this State acceptable in lieu of the examination which might be made of that child by the school medical inspector, has been introduced by Senator Ridolfi of Mercer County.

The findings of the subcommittee made on April 8 in its review of bills will be submitted in a supplemental report to the House of Delegates.

NATIONAL LEGISLATION

A significant reorganization of the A.M.A.'s legislative activities was directed by its House of Delegates at the mid-winter Clinical Meeting in Minneapolis. A marked change has been made in the Washington Office, with no real definition of its ultimate function or personnel yet decided. In general, it will be designed to be more effective in promoting A.M.A.'s aims by the development of improved working relationships with congressmen, at both the "grass-roots" and "Capitol Hill" levels.

H.R. 10 (Keogh-Simpson Bill) has passed the House and awaits the Senate's consideration. A four-man delegation, consisting of Dr. Featherston, Mr. Nevin, Mr. Backes (our legal counsel), and Dr. Blaisdell visited both Senators Case and Williams, stating our reasons for approving H.R. 10 and opposing the Forand type bills. The meeting with each Senator was friendly and, we hope, will be productive not only with respect to the two types of legislation listed but also in further considerations in the field of care for the aging.

Further information may be added in the subcommittee's supplemental report.

The chairman, co-chairman, and all members of the subcommittee wish to express their deep appreciation of the help and detailed work done by Mr. Nevin, his staff, and by the Legislative Analyst, Mr. Mincher. Thanks also go to Mr. C. Joseph Stetler, with the A.M.A. legal and executive staff, for his assistance and direction in coping with national legislation. Help from the Woman's Auxiliary and allied friendly organizations is also gratefully acknowledged.

Adopted (page 476)

Supplemental Report

On April 8, 1959, the subcommittee continued its study of pending state legislation. This included all the bills pertinent to the practice of medicine, to the physician, or to

the public health which had been introduced in the 1959 State legislature. Of the 31 bills which had been considered, the subcommittee's recommended positions—subsequently confirmed by the Board of Trustees, were:

Active opposition	1
Active support	1
Approval	13
Disapproval	9
No action	6
Action Deferred (pending receipt of additional information)	1

Adopted (page 476)

The Board of Trustees referred a considerable number of matters to the subcommittee, for study and report. The results of these studies are included in the annual and supplemental reports of the Board.

On April 15, 1959, a conference was held between representatives of the subcommittee and representatives of the Department of Education, who appeared to outline the reasons which they thought should induce support of A-125.

Medical Practice

(Reference Committee "E")

Irving Klompus, M.D., Chairman, Bound Brook

The major project of the subcommittee during the year has been the study of a relative value schedule and its application to The Medical Society of New Jersey. Briefly, such a schedule attempts to set up the values of various medical services in relation to each other, *i.e.*, an appendectomy may be 10 points, and a gastrectomy 25 points, an office call one point, and a night call three points. No attempt is made to set a dollar value on each point. Each specialty, or division of medicine, has been invited to suggest its own relative values. Every physician will set his own value per point, in dollars. This will be a truly intra-professional means of establishing fair, honest, and equitable fees. The schedule will represent the fees of the physicians of this State and can be utilized as the basis in any fee negotiations with outside agencies, such as insurance companies, government, and other non-medical groups; and the schedule will eliminate the further establishment of medical fees by these non-medical groups.

A joint meeting of the subcommittee was held with liaison representatives of the 21 New Jersey specialty groups; they voted unanimously to encourage development of the plan. The Board of Trustees then advised the subcommittee to proceed with the compilation of a relative value schedule for its consideration and action. We are in the process of compiling the suggestions of all the specialty groups, and hope this can be completed promptly. The subcommittee has spent over two years on this project, and it is our opinion that it has great merit as the proper method for assessing the value of medical services.

Several referrals from the Board of Trustees were investigated and reported back to the Board with recommendations. Among them were:

(1) Accident Report Fees—wherein an opinion of policy had been requested concerning physicians charging a fee for completing forms and supplying reports on accident patients to attorneys. The subcommittee recommended, and the Board of Trustees approved, that it is justifiable for the physicians of New Jersey to charge a fee for filling out reports in matters of litigation, and that such fee shall be reasonable and based upon the usual fees which prevail in the same community for similar physician's and surgeon's services;

(2) Optometrists and Drugs—wherein a member-ophthalmologist requested an opinion as to whether optometrists were exceeding the conditions of their licenses by prescribing and using drugs, such as fluorescein. Representatives from the subcommittee met jointly with the Special Committee on the Conservation of Vision to study and discuss the matter. The recommendations of the joint meeting were approved by the subcommittee and submitted to the Board of Trustees. They were: (a) That The Medical Society of New Jersey take the

position that the performance of any act included in the practice of medicine and surgery, by persons licensed to practice in other occupations, including optometry, unless such act is specifically authorized to them by law, is detrimental to the public interest and constitutes an infringement on the practice of medicine; and (b) That the Society use every means at its disposal to bring about the prosecution of optometrists who use drugs or otherwise engage in the illegal practice of medicine, and to bring about such strengthening of the Medical Practice Act as may be necessary, and clarification of the Optometric Act if necessary.

The work of the two special committees to the subcommittee—Industrial Health and Workmen's Compensation—are reflected in their individual reports.

The subcommittee experienced a great loss in the death of Andrew C. Ruoff, M.D., who, for so many years, had generously contributed his time, knowledge, and experience to the work of the Subcommittee on Medical Practice. We extend our deepest sympathy to his family.

Adopted (page 476)

Public Health

(Reference Committee "E")

ROBERT S. GARBER, M.D., Chairman, Belle Mead

For the most part the six special committees to this subcommittee have met diligently and continued to provide progressive reports at quarterly meetings. For more detailed information relative to the individual accomplishments, please refer to the specific role that each played this past year in their reports.

This committee received referrals from the Board of Trustees relative to mass x-rays on school children and the Mantoux test as well as a request from the State Department of Education for review and approval of a statement concerning tuberculosis screening of school children. These matters were acted upon appropriately and referred back to the Board of Trustees.

This committee accepted appointment as the Society's representative on the water storage referendum in an advisory capacity to the state-wide committee.

We were pleased to note that two of the three hearing and speech centers in operation were progressing satisfactorily; that the Board of Trustees acted upon our recommendation that the name of the Special Committee on School Health be changed to the "Special Committee on Child Health" and prepared the following recommendation:

> That, inasmuch as it has come to the attention of the Subcommittee on Public Health that there are some communities in the state in which diphtheria and poliomyelitis vaccinations are not required as pre-requisites to school, it was recommended that each component county medical society of The Medical Society of New Jersey encourage communities to make immunization against diphtheria and poliomyelitis mandatory as a pre-requisite to admission to school.

The committee continued to note with growing concern the status of the paramedical organizations and, consequently, felt that the Special Committee on Conservation of Vision should be authorized to prepare a series of informative articles for the guidance of physicians on the status of optometry and the A.M.A. position on that subject. We also suggest that a thorough and comparative study of the Optometric Act in relation to the Medical Practice Act be made by the Special Committee on the Conservation of Vision.

We note that the New Jersey Neuropsychiatric Association is concerned as to the effects in mental health resulting from non-medical personnel treating mental illness unsupervised. They are seeking to evolve a plan for legislation to control this practice in cooperation with the related professions of psychologists and social workers.

The Committee on Conservation of Vision successfully conducted an eye health screening program. The Special Committee on the Conservation of Hearing and Speech reported cooperation with the Trenton State Teachers College, Department of Otology and Speech

Pathology, relevant to the granting of a doctoral degree. Trenton otorhinolaryngologists and hospitals will cooperate in giving students special instructions in anatomy and physiology of the ear.

Further reassurance emanates from the fact that the Committee on Rehabilitation arranged for a fall meeting with all the county chairmen of county society committees on rehabilitation and that they were reviewing rehabilitation services as they pertained to Blue Cross, Blue Shield, and other benefits.

One of the considerable benefits of having an advisory representative of the Medical Society to the New Jersey Society of Technologists resulted from diligent activity on the part of the representative in meeting with this very effective group and reporting on their interests and desire to resolve effective relationships between our organizations.

We were pleased to note that the Special Committee on the Chronically Ill and Aging worked very closely in the AMA Conference with federal agencies on this subject and was endeavoring to work with the New Jersey Division for Chronic Illness of the State Department of Health in setting up a progressive program for the management of the chronically ill and aged. However, it was of grave concern to this committee that there remains no medical representation in the Division for Aging of the New Jersey State Department of Health.

Of considerable import to the Society is the fact that the chairman, with the chairman of the Committee on Mental Health, accepted the responsibility of appearing before the Mental Health Commission in conjunction with representatives of the New Jersey Neuropsychiatric Association on public hearings scheduled by the Legislative Mental Health Commission relative to modification of the commitment laws, treatment of the criminal insane, inspection of public and private mental hospitals and institutions for the care of the mentally retarded.

Again, it has been the chairman's privilege to have had the opportunity of working with active and interested members of this committee as well as the various chairmen and their members in promoting a dynamic program in reference to public health services for The Medical Society of New Jersey.

Adopted (page 476)

Public Relations

(Reference Committee "E")

JOHN F. KUSTRUP, M.D., Chairman, Trenton

The Subcommittee on Public Relations carried out its functions as outlined by the Board of Trustees. Two full committee meetings were held in the course of the year, together with special conferences of individual members entrusted with responsibility for particular projects.

CONTINUING PROJECTS

The projects approved for continuation throughout the year included:

(1) Publication and distribution of the *Junior Health Hints* series to the schools, *Health Hints* to the press, *Membership News Letter*, and *Periodic News Letter* to cooperating agencies.

(2) Preparation and publication of special news releases and publicity materials as required from time to time in furtherance of the Society's business and interests.

(3) Preparation for publication and distribution of a membership guide booklet.

(4) Continuance of a consultative service in support of the public relations activities of component societies.

(5) Completion of the format and achievement of the adoption of a New Jersey Medical-Press Guide to Cooperation.

(6) Encouragement of indoctrination programs under the sponsorship of component societies.

(7) Responsibility for the bestowal of the annual Golden Merit Award.

(8) Maintenance of a press clipping service for the Society's public relations features, releases, and press notices.

HEALTH HINTS, JUNIOR HEALTH HINTS AND SPECIAL NEWS RELEASES

Your committee is pleased to report that the *Health Hints* and *Junior Health Hints* continue to gain in popularity and general favor.

Issued over the name of Michael S. Newjohn, M.D., 26 *Health Hints* were supplied fortnightly to 320 daily and weekly newspapers and house organs throughout the State. Besides being presented in the newspapers to which they were supplied, they served as the basis for 33 separate editorials.

With the issuance of the 1958-59 series of *Junior Health Hints* (2,802 copies were made available to teachers and nurses in junior and senior high schools of the State, upon request), your subcommittee completed its four-year series, published in booklet form.

Eleven issues of the *Membership News Letter* were published and sent out. In the interest of efficiency and economy, the February issue of the *Membership News Letter* was given over to the Annual Meeting Committee for publication of the Advance Program for the 193rd Annual Meeting.

In furtherance of the Society's business and interests, the subcommittee cooperated with other agencies of the Society in publicizing the following significant activities:

In support of the Eye Health Screening Program, which was conducted by the Special Committee on the Conservation of Vision during the week of September 22, (1) an eight-page news release was sent to 547 newspapers, radio stations, and cooperating agencies; (2) a special news release in collaboration with the State Department of Health; (3) a *Health Hint* on the subject was sent to all newspapers in the State; and (4) materials were supplied to the Governor's Office for inclusion in one of the Governor's Sunday evening telecasts.

In behalf of the Special Committee on Traffic Safety, the subcommittee cooperated in a campaign of "Live and Let Live"—undertaken to achieve a decrease in highway accidents and fatalities in New Jersey. In furtherance of this project, a series of "spot announcements" to the public in the form of traffic safety suggestions were sent to all radio stations in New Jersey. The suggestions were embodied in fourteen contentious rhyming couplets, used to capture attention and interest. This campaign is currently under way throughout the State.

A special news release was sent to newspapers reporting that The Medical Society of New Jersey, by action of its Board of Trustees, had recorded its approval and support of the American Medical Association's recommendations regarding special health insurance coverage for people over sixty-five years of age with modest resources or low family income.

GOLDEN MERIT AWARD

Established by the Board of Trustees in 1956 upon the recommendation of the subcommittee, the purpose of the Golden Merit Award is to give deserved recognition and honor to members of The Medical Society of New Jersey who have held the degree of Doctor of Medicine for fifty years or more. The Golden Merit Award continues to be a source of heart-warming happiness both to the men and women receiving it and to all of the Society presenting it to them. According to our present knowledge, in 1959 nineteen awards will be given.

MEDICAL PRESS GUIDE

At its 1958 Annual Meeting, the House of Delegates approved the Medical-Press Guide which was evolved by a committee of the New Jersey Press Association and this subcommittee. Subsequently, the Board of Directors of the New Jersey Press Association reviewed the Medical-Press Guide and voted to sustain recommendations of its Executive Committee "that it would be in the best interests of both organizations involved for the Press Association to refrain from giving its approval of the Guide." This decision was based on the fact that "publishers and editors of NJPA member newspapers might very well feel that the organizations sponsoring publication and distribution of the Guide were endeavoring to infringe upon their prerogatives with respect to seeking out and publishing the news."

Your subcommittee points out that in all their deliberations, the committees of both organizations had as their constant goal the rendering of a service to the public, the members of the press, and the members of the medical profession of New Jersey that would not in any way infringe upon, but rather would recognize and protect, the right of all.

Thus it was that your subcommittee recorded its disappointment at this decision of the Press Association, particularly in view of the fact that before the two organizations agreed to cooperate on this project, careful thought was given to all that was involved. It was only with the official approval of both organizations that the committees went to work.

SPECIAL PROJECTS

The subcommittee approved the decision of the Special Committee on the Medical Student Loan Fund to accept individual commemorative donations to the fund and to issue acknowledgment cards therefor to both the donor and the family of the bereaved. The subcommittee commended this procedure for its public relations value, and cooperated in the preparation and distribution of the necessary cards.

In its desire to stimulate the establishment and operation of poison control centers throughout the State, the subcommittee published an official list of Poison Control Centers in operation in New Jersey in the January issue of the *Membership News Letter*.

Under the auspices of the subcommittee, a very successful day-long Public Relations Institute was held at the Executive Offices on February 1. Its purpose was to review all the pressing problems of public relations concern to The Medical Society of New Jersey and its component societies and, through formal presentation and forum discussion, to agree upon steps to deal with the situation.

To this meeting were invited officers and board members of The Medical Society of New Jersey; members of the Subcommittees on Public Relations and Medical Practice; presidents, secretaries, executive secretaries, and chairmen of public relations committees of component societies; and representatives of the Woman's Auxiliary.

PRESS COVERAGE FOR ANNUAL MEETING

Your subcommittee, for the past several years, has sponsored a Press Room at the annual meeting. It is supervised by the Executive Officer and the members of your subcommittee; the secretary to the Executive Officer is in charge. Through the Press Room, information is given to press representatives, interviews are arranged, and publicity pictures scheduled. Advance and spot news releases are handled through this unit. In 1958 our annual meeting was written up—in coverage embracing all its features—in a grand total of 178 newspaper articles, including two editorials. Twenty-three pictures were published.

The work of this subcommittee has been carried out faithfully in an attempt to further the good public relations of The Medical Society of New Jersey as regards the relation of doctor-and-doctor and doctor-and-patient, and the relations of medicine as an organized unit with the general public.

Adopted (page 476)

SPECIAL COMMITTEES OF THE MEDICAL PRACTICE COMMITTEE

Industrial Health

(Reference Committee "E")

WILLIS B. MITCHELL, M.D., Chairman, Toms River

The major portion of the past year was spent by the committee in studying the problems of industrial health and establishing a positive program.

Your chairman represented The Medical Society of New Jersey at the A.M.A. Joint Conference of State Committees on Industrial Health, in Cincinnati. This was a most informative conference, and the exchange of ideas with physicians of other states will be most helpful in the work of our committee.

One of the chief aims of the A.M.A. Council on Industrial Health is to stimulate interest in small plant medical coverage. About three-fourths of the working population is employed by small plants without benefit of even a part-time plant physician or some type of proper medical supervision.

The following was adopted as a program for the Special Committee on Industrial Health. It is our hope that this program can be implemented shortly.

1. Education

(a) In conjunction with the Society's Subcommittee on Public Relations, transmit information to the members regarding the aims and purposes of industrial medicine, and cooperation with private physicians.

(b) Dissemination of industrial medical information news of any research, preventive measures, new hazards, or toxicology, affecting health of employees.

2. Collection of information on industrial health, particularly by toxicology, research, and on industrial health in general.

3. Statistical information: Collation and interpretation of statistical information including a comparison of morbidity figures in various industries.

4. Establishment of reference sources including text books, journals, pamphlets, lectures and tape recordings.

5. Small plant medical coverage with a survey of our state situation, and the encouragement of the development of small plant coverage.

6. Work in cooperation with the Society's Committees on Workmen's Compensation, Rehabilitation, and others in establishing contact with state industrial accident commission, with the Workmen's Compensation Committee (Medical Advisory Committee), with the medical advisory committee to the state rehabilitation division, with management groups and with our Commission on the employment of the handicapped.

7. Screen State legislation in the field of industrial health in conjunction with the Society's Subcommittee on Legislation.

RECOMMENDATION

That the above program be implemented and continued in 1959-60.

Adopted (page 476)

Workmen's Compensation

(Reference Committee "E")

MARCUS H. GREIFINGER, M.D., Secretary, Newark

It was with deep regret that the Society learned of the death of Andrew C. Ruoff, M.D., of Union City, who had for many years served as a member of several committees of the Society, and at the time of his death was chairman of the Special Committee on Workmen's Compensation. Dr. Ruoff's death is a loss to the Medical Society and to his colleagues in the medical profession. Our deepest sympathy is expressed to his family in the loss of a loved one.

The following is based on a report of a committee meeting last summer, which was considered and approved by the Subcommittee on Medical Practice, the Welfare Committee, and the Board of Trustees:

The committee considered two referrals from the Board of Trustees:

1. A request from the United States Railroad Retirement Board for comments with regard to revision of the schedule of payment for examination of railroad retirement employees applying for sickness benefits, with the idea of bringing the schedule in line with present rates for medical services.

2. To investigate the practice of the State Workmen's Compensation Division in arbitrarily adopting the schedule of Blue Shield as the basis for all payments in workmen's compensation cases of state employees, and that corrective measures be initiated.

Concerning item 1, the special committee recommended (and this was approved) that in Railroad Retirement Board cases the fees shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians' and surgeons' and hospital services (R.S. 34:15-15).

On item 2, it was the recommendation of the special committee (which was approved) that the Society give serious consideration to making a pronouncement that the reasonable rate prevailing in the community should apply in all workmen's compensation cases, whether

on the part of the State of New Jersey or on the part of any insurance company.

The Board of Trustees, at its January meeting, adopted the following statement as its official pronouncement in the matter of workmen's compensation cases.

It has been and continues to be the opinion of the Board of Trustees of The Medical Society of New Jersey that employees of any subdivision of the state government should be covered in the same manner as employees of any other corporation, *i.e.*, fees should be allowed for treatment of these cases in accordance with the statute governing workmen's compensation—R.S. 34:15-15: "All fees and other charges for such physicians' and surgeons' treatments and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians' and surgeons' and hospital services;" that this opinion be forwarded to the Chief of the Claims Bureau, at the same time pointing out that this practice of arbitrarily adopting the Blue Shield schedule as the basis for all payments in workmen's compensation cases of state employees goes on in various state departments, particularly in the Claims Bureau of the Department of Law and Public Safety; and that a copy of the letter be sent to the Attorney General.

Adopted (page 476)

SPECIAL COMMITTEES OF THE PUBLIC HEALTH COMMITTEE

Child Health

(Reference Committee "E")

ROBERT E. JENNINGS, M.D., Chairman, South Orange

By action of the Board of Trustees last June, a recommendation was approved that the title of the Special Committee on School Health be changed to the Special Committee on Child Health, so that the committee would have a broader function, concerning itself not only with children of school age, but with the health and welfare of all children.

The nine-point school health program recommended in the 1957 annual report of the committee was reaffirmed, correcting item 8 which read: "The service of a school psychologist is tantamount with the detection and prevention of mental and emotional illness," to read: "The service of a school psychiatrist, or a school psychologist acting under the supervision of a school psychiatrist, is tantamount with the detection and prevention of mental and emotional illness."

The original nine-point program was returned to the committee to study whether it was in conflict with the "Four-Point School Health Program" adopted by the Medical Society several years ago, and the committee was instructed to consult with the New Jersey Chapter of the American Academy of Pediatrics and the Medical Division of the State Department of Education. The amended nine-point program has been approved by the New Jersey Chapter of the American Academy of Pediatrics (November, 1958). It has not been submitted to the New Jersey State Department of Education, pending an amendment to Chapter 25, P. L. 1955, Section 18:14-57. Request for such change was adopted by the House of Delegates in 1958 and was referred by the House to the Subcommittee on Legislation. An amendment to Chapter 25 has been prepared by the subcommittee, and approved by the Board of Trustees, and submitted to the 1959 legislature.

The committee cooperated with the Subcommittee on Public Health in developing recommendations regarding the tuberculosis screening of school children. Action was taken in response to requests from the State Department of Education and the New Jersey Tuberculosis and Health Association, Inc., which requests were referred by the Board of Trustees to the subcommittee for study and report.

The Special Committee on Child Health recommended that The Medical Society of New Jersey reaffirm its endorsement of fluoridation of local water supplies for the prevention of dental caries. This recommendation was

approved by the Subcommittee on Public Health but disapproved by the Welfare Committee, which referred it back to the special committee for further evaluation and report because of the controversial nature of the subject at this time.

A simplified history and physical examination form which would provide uniformity in forwarding results of physical examinations by family physicians to school or camp physicians is being studied. This form has the approval of the New Jersey Chapter, American Academy of Pediatrics.

Recognizing the urgency for immunization against poliomyelitis, diphtheria, pertussis, tetanus, and smallpox before admission to school, recommendations were made that were approved by the Subcommittee on Public Health and adopted by the Board of Trustees.

Prompted by a study of available material furnished by Dr. Felix Vann of Englewood, the committee is studying a comprehensive program on physical education and youth health patterned after the Wisconsin Plan on Physical Fitness. The committee has not had sufficient time to formulate its recommendations on this timely subject. It strongly urges that it be made a part of the program of the Special Committee on Child Health for 1959-60.

Adopted (page 476)

Chronically Ill and Aging

(Reference Committee "E")

William H. Hahn, M.D., Chairman, Newark

The name of this committee was changed from the "Committee on Chronically Ill" to the "Committee on Chronically Ill and Aging." This was in response to the great current interest which the problem of the aging is exciting today. The attention of the committee was called to the fact that a White House Conference on the Aging is scheduled for January 1961. There was also a Governor's Conference on the Aging, in Trenton on April 16, 1959, in preparation for the White House Conference.

The American Medical Association has pledged the support of all the members of the Association and of the state and county societies, and has promised full cooperation. The committee feels that the long interest of the Medical Society in this problem and its activities over a long period of years, in planning to meet their health needs, should prove of great help.

Our committee held three meetings during the year. It planned a program on chronic illness for the annual meeting, to be devoted to "Heart Disease, especially as related to Doctors." An exhibit has also been planned, composed chiefly of the results of a questionnaire addressed to members of our Society, concerning their own health.

A survey of our component societies shows that seven have active committees on Chronically Ill and Aging. Because of the many and varied interests in this problem, our committee is convinced that doctors can best aid in programs for the aging by acting in conjunction with county committees. Each county committee should establish liaison with all groups interested in the problem and provide leadership in their planning.

A meeting was held, to which all chairmen of county committees for chronically ill and aging were invited, and methods of organization were discussed.

The committee recommended that steps be taken to activate committees on chronically ill and aging in all component societies.

A new *Dietetic Manual* for use in hospitals has been published with the aid of the Division for Chronic Illness Control of the State Department of Health and the New Jersey Nutrition Council.

Adopted (page 476)

Conservation of Hearing and Speech

(Reference Committee "E")

S. Eugene Dalton, M.D., Chairman, Ventnor

The Special Committee on Conservation of Hearing and Speech is happy to report excellent progress and to offer suggestions for future development of Hearing and Speech Conservation.

The Newark Center has had 10,597 patient visits during the past year with 1,483 new patients evaluated. The Center has achieved an expansion of its program, the first of its kind, by establishing the "Center of Language Disorders," to deal with visual, auditory and perceptive disorders.

The Trenton Center at the St. Francis Hospital, has made rapid progress. It has expanded its geographic area of operation to include New Brunswick, Flemington, Lambertville and Bristol. The number of patients cared for in the past year has increased to 2,000. Recently an additional Speech Therapist has been added to the staff; he is using the electrogalvanometer. A weekly program of instructions for parents and guardians of Hearing and Speech patients has also been instituted.

The Atlantic City Hearing and Speech Center has been removed to the Children's Seashore House because the building in which the Center was formerly housed had to be demolished to make room for the new Atlantic City hospital building. Approval for the transfer of the center was given by the Staff, the Administrators, and the Board of Governors of the Atlantic City Hospital.

The Children's Seashore House accepted the new Center with enthusiasm; formal approval was given by the Administrator and the Board of Governors. The blueprints are on the drafting board for a new diagnostic center to house a modern Hearing and Speech department. It will also contain facilities for rehabilitation of victims of cerebral palsy and arthritis.

The committee makes the following suggestions for continuation of its program:

1. To expand the scope of the Hearing and Speech Centers now in operation and to organize new ones as they are needed.
2. To promote and assist in developing facilities for the training of audiologists and hearing and speech therapists under a program leading to a doctorate.

Adopted (page 476)

Conservation of Vision

(Reference Committee "E")

Charles E. Jaeckle, M.D., Chairman, East Orange

The full committee met three times in 1958-59; there were more numerous meetings of task-force subcommittees.

The state-wide Eye Health Screening Program was conducted during the week of September 21, 1958. About 175 ophthalmologists participated, working in 59 centers, utilizing the facilities made available by 57 hospitals and two other local agencies. A detailed report will be published.

Representatives of the Special Committee on Conservation of Vision and of the Subcommittee on Medical Practice prepared a report requested of the Subcommittee by the Board of Trustees, on the use of drugs by optometrists. The report has been approved by the Subcommittee on Medical Practice and forwarded to the Board of Trustees.

This Special Committee has made recommendations, approved by the Welfare Committee and now before the Board of Trustees, relative to (a) the classified telephone directory listing, "Contact Lenses"; (b) a study of the Optometry Act relative to the Medical Practice Act; and (c) a public relations proposal for acquainting the public with the service contributions of all physicians through medical clinics.

At the direction of the Board of Trustees the committee conferred with a representative

of Labor relative to the provision of medical eye care in the physician's office on a funded basis, and submitted a report to the Board of Trustees.

A report on the identification of school children for referral for eye care is in preparation.

Many of the projects on which this committee has worked are now, after processing through channels, before the Board of Trustees awaiting action at the time of this report.

Adopted (page 476)

Mental Health

(Reference Committee "E")

VINCENT P. MAHONEY, M.D., Chairman, Camden

During its two meetings this year the committee thoroughly considered the following matters:

1. A proposed movement of the Division of Constructive Health of the State of New Jersey to initiate diagnostic centers for mentally retarded children in specific locations throughout the state by utilizing the resources of general hospitals. The committee approved of the idea in principle, but there was a great deal of discussion as to how it was to be implemented. Questions were raised as to the relation of the hospitals to the physicians in this problem, and to whom the State would have contractual obligations. Just what control the physician-director would have over the process of evaluation should be clarified. The liaison representative between the Medical Society and the Department of Health has been invited to discuss this with us.

2. The suggestion by one of the committee members that certain psychiatric disease entities be considered reportable. This procedure would be advantageous for the following reasons: (a) from the statistical standpoint; (b) for insurance purposes; (c) to bring these diseases more readily under medical supervision. The committee felt that more discussion of this matter was needed prior to a definite recommendation being made.

3. The relationship between psychiatrists, psychologists, and psychiatric social workers. The committee made no recommendation in this matter, but reaffirmed its position that the treatment of the mentally ill person should be under medical supervision.

4. The difficulty experienced by epileptics in obtaining a driver's license and a license to marry. During this year, due no doubt to the previous committee's work and with the Society's official support, it was noted with great pleasure that the ban on marriage by epileptics was repealed. Definite recommendation will soon be made about epilepsy and drivers' licenses.

5. The mental health of the aged, particularly the increasing aged population in our mental hospitals. Because of the complexity of this problem, no specific recommendations can be made at this time. However, what material has been gathered is to be referred for the work of next year's committee. This is an urgent matter.

6. Graduate education. The chairman of this committee is aware of the efforts being made by the New Jersey Neuropsychiatric Association for the establishment of a regular annual course at Rutgers University, to physicians and those of the ancillary professions interested in psychiatry. The Special Committee on Mental Health has informed the New Jersey Neuropsychiatric Association that it will do all it can to aid in this matter.

Concerning the workings of this committee, the following two facts should be noted: (1) The chairman and many other members of the committee are in close touch with the New Jersey Neuropsychiatric Association whose Council meets monthly and gives attention to mental health problems throughout the State; (2) the New Jersey State Commission on Mental Health had two public hearings during the year. One dealt with the existing legislation pertaining to the licensing and inspection of public and private facilities, the diagnosis, care and treatment of the mentally ill, retarded, and deficient. The second hearing dealt with criminal responsibility of the psychotic and mentally deficient. Your committee chairman and the chairman of the Subcommittee on Public Health attended these meetings as official representatives of The Medical Society of New Jersey. Both were

in close touch with the New Jersey Neuropsychiatric Association whose representatives presented testimony at the hearings.

Our committee has recommended that the Medical Society, through its Special Committee on Traffic Safety, communicate with the Director of Motor Vehicles about epileptics obtaining drivers' licenses. The Committee on Mental Health has specifically recommended that epileptics be permitted to obtain drivers' licenses if they have been seizure-free with or without drugs for a period of two years.

Adopted (page 476)

Rehabilitation

(Reference Committee "E")

ELMER J. ELIAS, M.D., Chairman, Trenton

The program has been a continuation of that established two years ago, namely, the education of the physicians of New Jersey as to the significance of rehabilitation. Three points have been stressed:

1. Establishment of a Committee on Rehabilitation in each component society. This has been accomplished.

2. Devotion of one meeting in each component society each year to the subject of rehabilitation.

3. Investigation and survey of patients and treatment facilities available throughout the state.

A joint meeting of the committee with county chairmen on rehabilitation was held last October. Representatives from the Disability Determination Branch, New Jersey Rehabilitation Committee (Social Security); and from the Division of Welfare Services, New Jersey State Department of Institutions and Agencies (Disability Assistance), outlined the medical data required by their agencies in their studies of rehabilitation cases.

The committee has made some progress in the investigation and survey of patients and treatment facilities. However, the project will entail much more time and work than the committee members themselves can give to it. The existing rehabilitation services available in each county are largely unknown to the practicing physician and therefore are not being utilized. We believe, accordingly, that the Society should publish a New Jersey Directory of Rehabilitation Facilities and Services. As the most feasible method of developing the directory information each county should be surveyed by trained personnel. We will see if financial assistance might be obtained from private, philanthropic, or government agencies for the payment of the necessary trained personnel and publication of a directory. As soon as we have complete and definite information, a report with our recommendations, will be submitted through the proper channels.

RECOMMENDATION

That the present program be continued for 1959-60.

Adopted (page 476)

SPECIAL COMMITTEES

Civil Defense-Disaster Control

(Reference Committee "D")

R. Winfield Betts, M.D., Chairman, Medford

This committee keeps on quietly plodding along. At the end of the year it wonders just what had been accomplished to show for the many hours of work on the various problems assigned it.

Probably the most important function of the committee has been to act as a clearing house to which all of the problems brought to the attention of the President or the Board might be referred. There are many problems still under negotiation.

During the year the Executive Officer and the chairman of this committee attended a conference in Boston at which the various problems of the States in Region I (the New England States, New York and New Jersey) were aired with the AMA Committee on National Defense and the medical officers of OCDM (The new Office of Civilian and Defense Mobilization).

OCDM considered the comments concerning the situation in New Jersey sufficiently important to send the Regional Medical Officer, Dr. Jacob H. Landes, from Harvard to Trenton for a lengthy conference.

At present the problem in Civil Defense is a serious one. The entire advisory medical staff of Region I consists of one full-time physician. The entire medical staff of the New Jersey Department of Health, assigned to Civil Defense-Disaster Control also consists of one full-time physician. The responsibilities of this Department by law are to formulate, direct and supervise. The State of New York has 14 full time physicians for this job. New York has a well developed training program for its emergency hospital personnel. The obvious answer to the problem in New Jersey is more personnel. This has been recommended by this committee for years. Through the jaundiced eye of this committee it appears there is little likelihood of additional personnel being obtained. In New Jersey we must "keep our powder dry and Trust in the Lord."

Civil Defense is a government responsibility. The legislature made it so. The impetus behind the program, however, depends upon what concern the head of government has about this responsibility. This is true whether it be a Mayor, a Board of Freeholders or the Governor. Since there has been no particular concern exhibited by the head of our State government, his medical advisors have followed his lead and have exhibited no concern. As a consequence there has been but little activity in this State from a medical standpoint.

During the past year one of the most experienced men in Civil Defense in the country retired from the Army. It was known that he was receptive to an offer from this State and would consider it a challenge to work on Civil Defense Planning here. This committee suggested to the Board of Trustees that he be employed by this Society and assigned to the job of Civil Defense work for the Society. This was deemed not feasible. The Board did, however, strongly suggest to those "in high places" that he be employed by the State. He is employed elsewhere at this time.

This Society has repeatedly taken the attitude that the guidance and planning for Civil Defense are the responsibility of the State and it has no intention of usurping those responsibilities. The members of the Society have assured that they will cooperate to the limit of their time and endurance in any appropriate program which is promulgated by the Civil Defense-Disaster Control authorities and in which our cooperation has been requested.

Since this is the first year of OCDM it is expected there will be a lag before any breathtaking plans are formulated by this new agency. This is also an election year, and it becomes more apparent each year that Civil Defense depends not upon the need, but upon what the political fathers wish.

In order that the membership be kept abreast of new developments and planning, the committee has arranged space in The Journal for reporting Civil Defense activities. This material is being supplied by Dr. Marie Senna, of the State Department of Health. The first publication of such news will be in the May issue of The Journal. It is also suggested this space is an appropriate medium for any CD-DC news from the state membership. It is suggested such information be forwarded to the Society office for inclusion.

The committee regrets the death of one of its most ardent members, Dr. Andrew C. Ruoff. His passing is a loss to the Civil Defense effort in the State.

The committee does not necessarily believe in self-perpetuation. It does feel that it has gained some valuable background information on the CD-DC problem, obtained through the schools of heart breaks, hard knocks, and discouragement. It respectfully suggests that a committee should continue. Whether it be this committee, an augmented committee, or a different committee will be for the Society's official determination.

Adopted (page 475)

Medical Student Loan Fund

(Reference Committee "B")

F. Clyde Bowers, M.D., Chairman, Mendham

In the two years that the Medical Student Loan Fund has been in operation, twelve loans have been granted in the total amount of $10,675. The balance in the account at the date of this report, is $19,816 in the general fund, and $4,907 in the Albert Barker Kump Memorial Grant. The latter has not yet reached the $5,000 goal set when the grant was established last April. We sincerely hope the additional $93 required will be forthcoming soon.

The committee is limited to granting loans up to 20 per cent of the Fund in any year. In these two years of operation, we have had to turn down eight qualified students, because of lack of funds. If this Fund is to be truly self-perpetuating, there should be a revolving account of at least $100,000. We cannot expect much return on our loans for about 10 years. If, during the next six or seven years, the Fund could be brought up to $100,000, there would be sufficient money available to grant the loans requested by our own New Jersey medical students.

The committee is grateful to the many contributors to the fund and takes this occasion to acknowledge their generous support. The largest contributions were received from The Journal ($5,000) and from the Annual Meeting Committee ($5,382.26) paid from their advertising income and from the sale of technical exhibit booth spaces. A complete list of contributors to date follows:

ALBERT BARKER KUMP MEMORIAL GRANT

Morris County Medical Society, Dr. R. Grant Barry, Dr. James S. Shipman, Dr. William T. Read, Jr., Dr. Louis Kosminsky, Dr. Luke A. Mulligan, Dr. George A. Davies, Dr. Harry Halprin, Dr. Harold D. Barnshaw, Dr. Roger D. Lovelace, Dr. Norman D. Thetford, Dr. Bayard Coggeshall, Dr. Edwin R. Ristine, Dr. Henry H. Kessler, Dr. Aaron P. Gewanter, Dr. Louis A. Amdur, Dr. Harry L. Harwood, Dr. Joseph P. Donnelly, Dr. Harold Schwartz, Dr. Irvin Sussman, Dr. Myron J. Shapiro, Dr. Charles W. Buvinger, Dr. Robert L. Gilbertson, Dr. Samuel A. Cosgrove, Dr. Olga Haller, Dr. C. Byron Blaisdell, Dr. Edward G. Bourns, Dr. Elmer P. Weigel, Dr. George L. Erdman, Dr. Lancelot Ely, Dr. Jerome G. Kaufman, Dr. Severin T. Golojuch, Dr. James R. Herron, Atlantic County Woman's Auxiliary, Dr. Louis F. Raymond, Dr. Jesse W. Carll, Medical Associates of Dover, Dr. Lindley B. Reagan, Cumberland County Woman's Auxiliary, Dr. A. V. Simmons, Dr. Edgar P. Cardwell, Passaic County Medical Society, Dr. Maurice N. Harris, Gloucester County Medical Society, Dr. G. Barton Barlow, Mrs. John C. Voss, Dr. Jon M. Wilson, Dr. C. Fred Goeringer, Dr. Richard Kerdasha, Dr. Elmer J. Elias, Dr. Mary Bacon, Dr. Lloyd B. Whitman, Dr. H. Ameroy Hartwell, Dr. Paul P. Krikorian, Dr. Frederick W. Durham, Dr. John L. Olpp, Dr. John S. Madara, Dr. William B. McGuinn, Dr. Major Darst, Jr., Dr. Leonard G. Scott, Dr. Ralph M. L. Buchanan, Dr. Sherman Garrison, Jr., Dr. Nathan B. Heller, Camden County Woman's Auxiliary, Gloucester County Woman's Auxiliary, State Woman's Auxiliary, Dr. Edwin C. Greene, Dr. F. Clyde Bowers, Dr. Charles E. Jaeckle, Ocean County Medical Society, Dr. Louis S. Wegryn, Dr. Lloyd A. Hamilton, Mrs. Albert B. Kump, Dr. Royal A. Schaaf, Jonathan Moore, D. O., Cumberland County Medical Society, Essex County Medical Society, Bergen County Medical Society, Essex County Woman's Auxiliary, Somerset County Medical Society, Camden County Medical Society, and the Board of Trustees in memory of Dr. Andrew C. Ruoff.

GENERAL FUND

Pfizer Golf Tournament, State Woman's Auxiliary, The Journal, Bergen County Woman's Auxiliary, Burlington County Woman's Auxiliary, Essex County Woman's Auxiliary, Cumberland County Woman's Auxiliary, Hudson County Woman's Auxiliary, Hunterdon County Woman's Aux-

iliary, Passaic County Woman's Auxiliary, Salem County Woman's Auxiliary, Union County Woman's Auxiliary, Annual Meeting Committee, Middlesex County Woman's Auxiliary, and donations in memory of friends: Mrs. Albert B. Kump, Dr. and Mrs. Gorman Jaffe, Burlington County Medical Society, State Woman's Auxiliary Executive Board, Ocean County Medical Society, Dr. and Mrs. Lloyd A. Hamilton, Ocean County Woman's Auxiliary, Mrs. Joseph Ziegler, Dr. Goldenberg's office staff, Dr. and Mrs. Samuel Ellenson, Dr. and Mrs. Oliver H. Bricker, Dr. and Mrs. Keith R. Young, and neighbors of Mr. Robert G. Bloomer.

Early in its experience the committee found that the demand for loans was much greater than our Fund could satisfy. Also, we became aware of the fact that there were several other New Jersey organizations which, in one form or another, were interested in aiding medical students. Some programs were in the form of outright gifts. Others, like ours, were limited loans. It is impossible for an applicant to know of all the possibilities of obtaining assistance in New Jersey. We felt that it would be desirable to establish a clearing house of information on such programs. This was recommended to the Board of Trustees, with the further recommendation that our committee serve in this capacity; and the recommendations were approved by the Board.

Contact was made with the several specialty societies throughout the State. We learned that there are three other medical student loan funds in New Jersey, and full details of the operation of each fund is on file. This information will insure a more effective use of the available funds through a better understanding on the part of an applicant, as well as of the organization making the loan. We may find that an applicant is eligible in one plan and not in others; or an organization may have more applicants than it can handle, in which event these students could be referred to the clearing house for advise. Our only objective is to assemble data and make it available to applicants. We will in no way interfere with the operation of the individual plans.

With the approval of the Board of Trustees, the committee will raffle a 70-piece dinner set for eight of Lenox china during the Annual Meeting. A permit to conduct the raffle was obtained from the State Commission and the necessary license was obtained from Atlantic City. Tickets will be sold only to those who register at the convention, the price will be $2.00 per ticket. The drawing is scheduled for 1:00 p.m. on Wednesday, April 29, 1959. We sincerely hope that each member will purchase at least three or four tickets. These will be sold by members of the Woman's Auxiliary who have graciously consented to donate their time and services to the project. If the sale of tickets reaches our expectations, the gross receipts—which will be turned over to our Fund—should enable us to provide loans to at least two more students than would now be possible. Through the courtesy of Mead Johnson and Company, the purchase of the china was made possible without cost to the Society or the Fund. We are deeply grateful to Mead Johnson for this generous gesture.

Again the committee urges wide and continuing publicity of the Medical Student Loan Fund to the membership. It appeals for contributions, either to the general fund or as specific memorial grants.

Adopted. Reference committee recommendation that all members of the Society think of this Fund as a philanthropy to which they judiciously contribute—Adopted **(page 472)**

Physicians Placement Service

(Reference Committee "D")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

The Physicians Placement Service continues as the New Jersey center for exchange of information between physicians and communities. Physicians desiring to practice in New Jersey are supplied with descriptive lists of areas suitable for the establishment of a practice. Likewise, lists of physicians wishing to locate in the State are distributed to local officials who feel their communities require additional practicing physicians. Such lists are also made available to practicing physicians in need of assistants or associates, to industries interested in obtaining medical personnel, and to divisions of the State government desiring to employ physicians.

Inquiries received during 1958-59 from physicians interested in establishing a practice in New Jersey		237
Referred by the A.M.A.	91	
Direct inquiries	146	
Included in Quarterly Reports		198
Located in New Jersey		23 or 10%
Located elsewhere or dropped from list because of failure to respond to follow-up communications	124	
Retained on active list		51 or 21%

As indicated in previous reports, the majority of registrants are seeking association with other physicians; few desire to establish a solo private practice. The demand for general practitioners outweighs the number available. Most applicants are interested in establishing a specialty practice.

Applicants register too far in advance of the date they will be available.

Last summer a representative of the A.M.A. Council on Medical Service (Physicians Placement Service) visited the executive offices to observe the operation of our placement program and to discuss common problems. It became evident that New Jersey's problems are not unique; they prevail throughout the country.

Clerical procedures connected with the operation of the Placement Service are carried on by members of the executive office staff as part of their regularly assigned duties.

Adopted (page 475)

Traffic Safety

(Reference Committee "D")

A. M. K. Maldeis, M.D., Chairman, Camden

During the past few months, following the application of the new traffic regulations, there has been a noticeable decline in fatalities from traffic accidents. This change has been chiefly the result of the mandatory imposition of severe penalties for speeding on the highways. With improvements in other driving standards, the opportunity for a still better traffic picture may be seen. The State Department of Law and Public Safety is to be commended for its action.

An offer of such help in the matter of traffic safety as the physicians and The Medical Society of New Jersey are able to give has been made to the New Jersey Director of Motor Vehicles.

At a session of the Special Committee on Traffic Safety, an exploratory meeting of this committee with representatives of the Bar Association of New Jersey and the Subcommittee on Legislation of The Medical Society of New Jersey was considered advisable. The purpose of such meeting was the development of recommendations to deal with drivers under the influence of alcohol, and other drugs and medications. Such a meeting was authorized by the Board of Trustees. Action upon a phase of this matter is pending in the New Jersey legislature. At an appropriate time a meeting with the Bar Association will be sought.

Pamphlets entitled "Are You Fit to Drive?" issued by the American Medical Association, were given to the Woman's Auxiliary for distribution at county level.

A leaflet—embodying safe driving recommendations—for distribution to physicians of New Jersey is being prepared by the Executive Officer at the request of this committee.

An article by this committee, "Traffic Safety and You," was published in the March issue of the *Membership News Letter*.

The Board of Trustees authorized a program of statewide radio broadcasting of spot announcements to the public in the interest of traffic safety. This program followed the suggestion of an officer of the Broadcasting Association of New Jersey. The spot scripts have been written and approved by The Medical Society of New Jersey through our Subcommittee on Public Relations. Except for incidental stationery expenses, no cost to the Society is involved. Spot scripts are now being used by radio stations throughout New Jersey.

Physicians, as leaders in their communities, have a double duty in conjunction with traffic safety; to preach safe driving, and to practice it. Let us all remember, too, that actions speak louder than words.

Adopted (page 475)

Retirement Plan for Physicians

(Reference Committee "D")

JEROME G. KAUFMAN, M.D., Chairman, Newark

In compliance with the directive of the 1958 House of Delegates, early in the administrative year, the President appointed a three-man probing committee to study and prepare recommendations concerning the purpose and intent of the Mercer County Resolution dealing with a retirement plan for physicians in affiliation with the Medical-Surgical Plan of New Jersey.

That committee held two meetings in the course of its investigations and obtained permission of the Board of Trustees to avail itself of the services and advice of the Society's legal counsel.

The President then brought the committee to its full complement. The full committee met on March 8, to receive the report of the work done by the probing committee.

Dr. Moriconi explained the nature and intent of the Mercer County Resolution. Extended discussion from the floor followed. All of the speakers expressed disapproval of the proposal to create the retirement plan by means of contributions from Medical-Surgical Plan—regarding the proposal as of doubtful legality and morality.

Legal counsel, Mr. Backes, then presented his opinions concerning the acceptability and feasibility of the proposal. Mr. Backes said, in effect that the proposal contained in the Mercer County Resolution—that the Medical-Surgical Plan participate in the foundation of the retirement fund—called upon the corporation to act beyond the purposes for which under the law it was set up. He also made it clear that in his opinion the proposal very definitely raised a serious moral issue.

Dr. Moriconi then moved that the retirement plan as embodied in the Mercer County Resolutions be withdrawn. Dr. Lloyd seconded. The motion was unanimously adopted.

Then, upon suggestion of President Gardner, the committee unanimously adopted a motion to empower a subcommittee of the full committee, with Dr. Kaufman as chairman, to study the possibility of the establishment of another type of retirement plan for members of The Medical Society of New Jersey, and to prepare recommendations with reference thereto.

Adopted (page 475)

Revision of Constitution and Bylaws

(Reference Committee on Constitution and Bylaws)

LOUIS F. ALBRIGHT, M.D., Chairman, Asbury Park

We here offer proposed revisions to a few sections of the Constitution and the first half of the Bylaws, with a complete proposed revision of the last half of the Bylaws. This completes the work of your committee which began three years ago: a complete revision of the Constitution and Bylaws to bring it up to date in all respects.

Several meetings of the committee were held this year, the final one on January 25—a Constitutional Convention—with representatives of the component societies. The proposed revision received the almost unanimous approval of the convention, both delegates and committee members.

The revision of the Constitution and Bylaws has been a difficult task, but one which your committee was glad to perform in the interest of our Society. As evidenced by the proposed revisions to the Constitution and the first half of the Bylaws, the matter of putting theory into practice does not always follow. We have endeavored to produce sound rules and regulations, not only in theory, but in practice. However, this may not follow through in all instances and practical application of our

theory may be found to be impossible and revisions may necessarily have to be made later. We trust, however, that our recommendations for revision at this time will be adopted and given a fair trial. Your committee feels that its proposals will provide a sound and well-organized system of procedural codes. We believe them to be free of elements of unfairness and ambiguity and to be comprehensive and complete. We urge the adoption of the proposed revisions to the Constitution and Bylaws.

CONSTITUTION

Current

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of this Society.

Section 4 — Delegates

(a) *Apportionment and Election.* Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 of the fiscal year by a majority ballot of the members present. Each delegate shall be elected for three (3) years. Each component society shall be entitled to at least three (3) delegates.

ARTICLE IX—OFFICERS

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

Proposed

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

Add the following footnote:

(The "immediate past-president" is that living past-president between whom and the presidency no succeeding living past-president intervenes.)

Accepted for final consideration in 1960 (page 478)

Section 4 — Delegates

(a) *Apportionment and Election.* Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Accepted for final consideration in 1960 (page 478)
Article IV amendments accepted for final consideration in 1960 (page 478)

ARTICLE IX—OFFICERS

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office, except that of President-Elect, occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

Article IX amendment accepted for final consideration in 1960 (page 478)

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. *Procedure for First Year*

1. Submission of the proposed amendment in writing, through the Secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws and to each component society by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. *Procedure for First Year*

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

(Renumber balance—paragraph 2 becomes 3, etc., ending with paragraph 10 becoming 11)

Article XII amendments accepted for final consideration in 1960 (page 478)

BYLAWS

(Chapter XV—Amendments: These By-Laws may be amended at annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day.)

NOTE: *This means in effect that amendments must be presented at the first session in written form suitable for reading in open meeting.*

Current

CHAPTER II—MEETINGS

Section 2 — Special Meetings

Special meetings of this Society or of the House of Delegates shall be called by the President upon the request of the Board of Trustees, or upon the petition of at least five per cent (5%) of the membership of this Society representing at least ten per cent (10%) of the membership of each of four (4) or more component societies.

Proposed

CHAPTER II—MEETINGS

Section 2 — Special Meetings

(a) Special meetings of this Society or of the House of Delegates shall be called by the President upon the request of the Board of Trustees, or upon the request of the House of Delegates while in session, or upon the written petition of at least five per cent (5%) of the membership of this Society representing at least ten per cent (10%) of the membership of each of four (4) or more component societies.

(b) A special meeting shall be called for a specific purpose with the time and place, unless otherwise specified, left to the discretion of the President.

Amendment to Chapter II—Adopted (page 478)

CHAPTER III—GENERAL SESSIONS AND SECTION MEETINGS

Section 2 — Section Meetings

(a) Section meetings shall be for the presentation of scientific papers and discussions related to the medical or surgical specialty designated and as provided in the program. These section meetings shall be under the guidance of a presiding officer chosen by each section at its preceding meeting.

(b) At a regularly etc.

CHAPTER III—GENERAL SESSIONS AND SECTION MEETINGS

Section 2 — Section Meetings

(a) Section meetings shall be for the presentation of scientific papers and discussions related to the sections designated and as provided in the program.

(b) Each section shall have a chairman and a secretary, who shall serve for one (1) meeting, after which the secretary shall become the chairman for the next meeting of the section. The secretary for the next meeting shall be selected during the business meeting, for which at least ten (10) minutes shall be scheduled in the program of each section meeting.

(c) The chairman shall preside at the section meeting. The section program shall be prepared under the guidance of the chairman, with the final program subject to the approval of the Committee on Annual Meeting.

(d) At a regularly etc.

Amendment to Chapter III—Adopted (page 478)

CHAPTER V—PROCEDURE OF ELECTION

Section 3 — Report and Election

(d) The President-Elect etc.

CHAPTER V—PROCEDURE OF ELECTION

Section 3 — Report and Election

Insert the following paragraph:

(d) When a member who already holds an elective office is elected to a second office, the presiding officer shall then declare the previous elective office vacant. This vacancy shall then be filled immediately by nomination from the floor and election by the House of Delegates.

(e) The President-Elect etc.

Amendment to Chapter V—Adopted (page 478)

CHAPTER VI—RIGHTS AND DUTIES OF OFFICERS

Section 2 — The President-Elect and the Vice-Presidents

. . . . . .

In case of vacancy in the office of President, by death, resignation, or removal, the President's functions and duties shall devolve upon the other presidential officers in the order of

CHAPTER VI—RIGHTS AND DUTIES OF OFFICERS

Section 2 — The President-Elect and the Vice-Presidents

. . . . . .

In case of vacancy in the office of President, by death, resignation, or removal, the President's functions and duties shall devolve upon the other presidential officers in the or-

their seniority. Such service on the part of a presidential officer for a partial term as President shall not affect or diminish the regular presidential tenure.

der of their seniority, the President-Elect becoming President automatically. The office of President-Elect shall then remain vacant until the next regular election of the House of Delegates. In case a vacancy in the office of President recurs after being filled by the President-Elect, the presidency shall devolve upon the Vice-Presidents, in the order of their seniority. Such service on the part of a presidential officer for a partial term as President shall not affect or diminish the regular presidential tenure.

Amendment to Chapter VI—Adopted (page 478)

CHAPTER VIII—COMMITTEES

Section 1 — Classification

There shall be Standing Committees, Reference Committees, and Special Committees.

CHAPTER IX—ADMINISTRATIVE COUNCILS AND COMMITTEES

Section 1 — Classification

There shall be Administrative Councils, Standing Committees, Reference Committees, a Nominating Committee, and Special Committees.

Adopted (page 478)

Section 3 — Appointments

Standing Committees, unless otherwise provided, shall be appointed by the President, and he shall designate the chairmen. The President shall be a member ex-officio of all the above named committees except the Nominating Committee. Unless otherwise ordered in these By-Laws, committee members shall serve for three years; provided that in committees of three members no two terms shall expire in the same year; and in committees of six members not more than two terms shall expire in the same year.

Section 2 — Qualifications, Selection, and Terms of Members

(a) No person other than a member of The Medical Society of New Jersey shall serve as a member of an administrative council or committee. A non-member may be designated as an advisor, observer, or consultant to an administrative council or committee.

(b) Membership on a reference committee shall be restricted to members of the House of Delegates. Members of committees who are not members of the House of Delegates may present their reports in person to the House and may participate in debate thereon, but shall not be entitled to vote.

(c) Members of administrative councils and standing committees shall be selected as provided in these Bylaws. The President shall designate the chairman and vice-chairman of each administrative council and standing committee. The President shall be a member ex-officio of all administrative councils and standing committees.

(d) Unless otherwise ordered in these Bylaws, the term of service for members of ad-

ministrative councils and standing committees shall be for three (3) years.

(e) No member of any administrative council or standing committee, except the Council on Legislation, shall serve for more than three (3) consecutive terms, but a member selected to serve an unexpired term shall not be regarded as having served a term unless he has served more than two (2) years.

(f) Members of administrative councils and standing committees shall assume their duties at the close of the last session of the House of Delegates of the annual meeting at which the elected members were elected.

Adopted (page 478)

Section 3 — Meetings

All meetings of administrative councils and committees should be held in the Executive Offices of The Medical Society of New Jersey in Trenton, except during the annual meeting.

Adopted (page 478)

Section 2 — Standing Committees

The Standing Committees shall be:
Nominating Committee
Committee on Finance
Committee on Annual Meeting
Publication Committee
Honorary Membership Committee
Welfare Committee
Committee on Medical Education
Medical Defense and Insurance Committee
Woman's Auxiliary Committee
and such other committees as the House of Delegates shall determine.

Section 4 — Administrative Councils and Committees

(a) The Administrative Councils shall be:
Council on Legislation
Council on Medical Services
Council on Public Health
Council on Public Relations

(b) The Standing Committees shall be:
Committee on Annual Meeting
Committee on Credentials
Committee on Finance and Budget
Committee on Honorary Membership
Committee on Medical Defense and Insurance
Committee on Medical Education
Committee on Medical Student Loan Fund
Committee on Publication
Committee on Revision of Constitution and Bylaws
Advisory Committee to the Woman's Auxiliary

(c) Special Committees shall be those established by the House of Delegates or the Board of Trustees as provided in Section 19 of this Chapter.

Section 4 — Nominating Committee

The Nominating Committee shall be selected and shall function according to the provisions of Chapter V of these By-Laws.

Section 9 — Welfare Committee

The Welfare Committee shall consist of not more than sixty (60) members, exclusive of Consultants, appointed annually, which number shall include the President and Secretary of this society, ex-officio. Each component county society shall be represented by at least one member, and candidates for such appointment may be suggested to the President by each component society. It shall keep minutes and records of its transactions. It shall have supervision over legislative matters, public health, public relations, and medical practice, subject, when necessary, to direction from or approval by the Board of Trustees or the House of Delegates. To this committee shall be referred all questions of professional welfare not included in the specific work of the Judicial Council. It shall be empowered to employ a special agent or agents, and to expend such moneys as shall be approved by the Committee on Finance and the Board of Trustees. The work of this committee shall be divided into four sub-committees—public health, legislative, medical practice, and public relations. Each sub-committee shall consist of five members appointed annually and its chairman shall be appointed by the chairman of the Welfare Committee with the approval of the President. Special Advisory Committees, of not more than fifteen (15) members each, to these committees may be formed on the approval of the Board of Trustees, and the members shall be appointed by the President.

(d) Reference Committees shall be those appointed by the President as provided in Section 20 of this Chapter.

(e) A Nominating Committee shall be selected as provided in Chapter V.

Adopted (page 478)

Section 5 — Council on Legislation

(a) The Council on Legislation shall consist of twelve (12) members, six (6) of whom shall be elected by the House of Delegates, and six (6) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of two (2) elected and two (2) appointed members expire. There shall be at least one (1) elected and one (1) appointed member from each judicial district. Candidates for appointment may be suggested to the President by the component societies in the district in which a vacancy exists.

(b) The function of the Council on Legislation shall be to study and evaluate legislation—at state and national levels—proper to the interests of this Society. Other assignments in the field of legislative concern, such as the preparation of legislation, may be given to the council by the House of Delegates or the Board of Trustees.

(c) The recommendations of the council shall be subject to the approval of the Board of Trustees before they become the official positions of this Society.

(d) The Chairman of the Board of Trustees shall be a member, ex-officio, of the Council on Legislation.

Adopted (page 478)

Section 6 — Council on Medical Services

(a) The Council on Medical Services shall consist of twelve (12) members, six (6) of whom shall be elected by the House of Delegates, and six (6) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of two (2) elected and two (2) appointed members expire. There shall be at least one

(1) elected and one (1) appointed member from each judicial district. Candidates for appointment may be suggested to the President by the component societies in the district in which a vacancy exists.

(b) The function of the Council on Medical Services shall be to study and evaluate matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, to investigate matters pertaining to the economic and social aspects of medical care, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of medical service.

(c) The President-Elect shall be a member, ex-officio, of the Council on Medical Services.

Adopted (page 478)

Section 7 — Council on Public Health

(a) The Council on Public Health shall consist of twelve (12) members, six (6) of whom shall be elected by the House of Delegates, and six (6) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of two (2) elected and two (2) appointed members expire. There shall be at least one (1) elected and one (1) appointed member from each judicial district. Candidates for appointment may be suggested to the President by the component societies in the district in which a vacancy exists.

(b) The function of the Council on Public Health shall be to study and evaluate all matters of interest to this Society in the field of public health, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of public health.

(c) The First Vice-President shall be a member, ex-officio, of the Council on Public Health.

Adopted (page 478)

Section 8 — Council on Public Relations

(a) The Council on Public Relations shall consist of twelve (12) members, six (6) of whom shall be elected by the House of Delegates, and six (6) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of two (2) elected and two (2) appointed members expire. There shall be at least one (1) elected and one (1) appointed member from each judicial district. Candidates for appointment may be suggested to the President by the component societies in the district in which a vacancy exists.

(b) The function of the Council on Public Relations shall be to evaluate, suggest, and —with approval—carry out programs and projects calculated to further the public relations of this Society; and to report findings and recommendations to the Board of Trustees relative to official policies, positions, and activities of this Society in the field of public relations.

(c) The Second Vice-President shall be a member, ex-officio, of the Council on Public Relations.

Adopted (page 478)

Section 6 — Committee on Annual Meeting

The Committee on the Annual Meeting shall consist of five members. It shall have complete charge of all arrangements, plans and programs for the annual meeting and all details pertaining thereto. It shall provide suitable accommodations for the annual meeting, viz: for the general and section sessions, house of delegates, trustees, committees, woman's auxiliary, and exhibits. The general plans for the annual meeting shall be subject to the approval of the Board of Trustees and shall be reported to them at intervals, with a complete outline at least four months before the meeting.

This committee shall have two sub-committees, one on scientific program and one on scientific exhibits.

One member of the committee shall be designated by the chairman, with the consent of the President, as Chairman of the Sub-Committee on Scientific Program. It shall

Section 9 — Committee on Annual Meeting

(a) The Committee on Annual Meeting shall consist of six (6) members, three (3) of whom shall be elected by the House of Delegates, and three (3) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of one (1) elected and one (1) appointed member expire.

(b) The committee shall have complete charge of all arrangements, plans, and programs for the annual meeting, and all details pertaining thereto. It shall provide suitable accommodations for the general sessions, section meetings, House of Delegates, Board of Trustees, committees, Woman's Auxiliary, and exhibits.

(c) The general plans for the annual meeting shall be subject to the approval of the Board of Trustees, and shall be reported to

be his duty to arrange for papers, addresses and orations for the annual meeting. He shall see that the speakers are properly received at the annual meeting and that the scientific papers are delivered as scheduled. He may appoint two other men to assist him in the work of this sub-committee. The classification and number of scientific sections shall be determined by the sub-committee. The chairman and secretary of the scientific sections shall be elected by each section, but shall be responsible to the chairman of the scientific program and shall report to him.

Another member of the Committee on Annual Meeting, shall be designated by the chairman, with the consent of the President, as the chairman of the Sub-Committee on Scientific Exhibits. He may in turn designate two other members with the consent of the chairman, to act as a sub-committee on scientific exhibits. The duty of this sub-committee shall be to prepare and arrange for all details in connection with scientific exhibits of the annual meeting.

it at intervals, with a complete outline at least four (4) months in advance of the annual meeting.

(d) The number of sections shall be as provided in Article VIII of the Constitution. A member of the Committee on Annual Meeting may be appointed by the chairman as Chairman of Scientific Program, to work with the section officers in the preparation of the section programs. All section programs shall be approved by the committee before being scheduled for presentation at the annual meeting.

(e) Exhibits shall be divided into three (3) classifications and be so listed in the program: scientific, technical, and educational. The committee shall have authority to make and enforce rules and regulations governing exhibits and exhibitors. A member of the committee may be appointed by the chairman as Chairman of Scientific Exhibits to supervise the details in connection with exhibits. With the consent of the chairman, he may in turn designate up to four (4) other members as assistants.

(f) The Secretary shall be a member, ex-officio, of this committee.

Adopted (page 478)

Section 10 — Committee on Credentials

(a) The Committee on Credentials shall consist of seven (7) members, six (6) of whom shall be appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of two (2) expire. There shall be at least one (1) member from each judicial district.

(b) The Secretary shall be the seventh member of the committee. He shall serve as its chairman and be responsible for the maintenance of the official files of the committee.

(c) The Committee on Credentials shall review and act upon all applications for membership in component societies. It shall report its actions in writing to component societies.

(d) The committee shall provide component societies with official membership application forms, and it shall devise and adopt an

official form for reporting and recording its actions.

Adopted (page 478)

Section 5 — Committee on Finance

The Committee on Finance shall consist of three members elected by and from the Board of Trustees, and three members elected by and from the House of Delegates, and their term of office shall be for six years; provided that the term of one Trustee member shall expire every second year, and the term of one Delegate member on each alternate year. The Treasurer shall be a member ex-officio, his capacity being advisory and without vote except in case of tie. The committee shall elect its own chairman. It shall prepare a budget to be submitted to the House of Delegates at the annual meeting, and shall control the expenditure of money by officers and committees, as provided in Chapter IX of these By-Laws. The committee is hereby authorized to require from any officer or committee any necessary fiscal information.

Section 11 — Committee on Finance and Budget

(a) The Committee on Finance and Budget shall consist of six (6) members, three (3) of whom shall be elected by and from the Board of Trustees, and three (3) elected by and from the House of Delegates. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of one (1) trustee-member and one (1) delegate-member expire.

(b) The Committee on Finance and Budget shall control the expenditure of money by officers, councils, and committees, as provided in Chapter X of these Bylaws. Annually it shall prepare a budget to be submitted to the House of Delegates.

(c) The Committee on Finance and Budget shall be empowered to obtain from any officer, council, or committee any necessary fiscal information.

(d) The Treasurer shall be a member, ex-officio, of the Committee on Finance and Budget.

Adopted (page 478)

Section 8 — Honorary Membership Committee

The Committee on Honorary Membership shall be composed of three Fellows. It shall inquire into the standing and qualifications of all nominees for honorary membership in the society, and report the same with recommendations to the House of Delegates.

Section 12—Committee on Honorary Membership

(a) The Committee on Honorary Membership shall consist of three (3) Fellows, appointed by the President for terms of three (3) years, so arranged that at each annual meeting the term of one (1) expires.

(b) The committee shall pass upon the qualifications of all nominees for honorary membership in this Society, and shall report its recommendations to the Board of Trustees in accordance with the provisions of Section 7, Article IV of the Constitution.

Adopted (page 478)

Section 11 — Committee on Medical Defense and Insurance

The Committee on Medical Defense and Insurance shall consist of seven members, and shall have charge of all matters pertaining to alleged malpractice of members, and all other types of insurance, such as health, accident,

Section 13 — Committee on Medical Defense and Insurance

(a) The Committee on Medical Defense and Insurance shall consist of six (6) members, three (3) of whom shall be elected by the House of Delegates, and three (3) ap-

life, and automobile, which may be recommended to the members.

It shall have the responsibility for the protection of the members and the contracts and relations with the insurance company. It shall at all times be cognizant of the financial responsibility of the insurance companies, brokers, and agents with whom it is dealing, and shall make frequent reports to the Board of Trustees and annually to the House of Delegates on these matters. It shall not enter into contracts without the approval of the Board of Trustees or the House of Delegates. It shall maintain contact with the Judicial Council and refer complaints of an ethical nature to that body.

pointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of one (1) elected and one (1) appointed member expire.

(b) The committee shall have responsibility for making available optimum protection of all members, by investigating and recommending suitable insurance coverage in the fields of professional liability, accident and health, and any other areas which shall come to be regarded by a majority of the members as necessary or desirable.

(c) It shall act in the interest of the members in all negotiations or disputes with commercial carriers.

(d) It shall make recommendations concerning contractual agreements to the House of Delegates or Board of Trustees.

(e) It shall refer to the Judicial Council all complaints or accusations brought to its attention concerning the professional conduct or ethical deportment of members of this Society.

(f) It shall report frequently to the Board of Trustees and annually to the House of Delegates concerning its activities.

(g) The Secretary shall be a member, ex-officio, of this committee.

Adopted (page 478)

Section 10 — Committee on Medical Education

The Committee on Medical Education shall consist of five members. The first appointment shall be for a period of one (1) year; the second appointment shall be for a period of two (2) years; the third appointment shall be for a period of three (3) years; the fourth appointment shall be for a period of four (4) years; the fifth appointment shall be for a period of five (5) years; and as the terms of these members expire, new appointments shall be for periods of five years. It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in cooperation with educational institutions.

Section 14 — Committee on Medical Education

(a) The Committee on Medical Education shall consist of six (6) members, three (3) of whom shall be elected by the House of Delegates, and three (3) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of one (1) elected and one (1) appointed member expire.

(b) It shall be the duty of this committee to serve as the contact committee with the medical and dental schools in this State.

Adopted (page 478)

Section 7 — Publication Committee

The Committee on Publication shall consist of three members elected by the House of Delegates, with the Secretary an additional member ex-officio, and the Editor of the Journal sitting with the committee in an advisory capacity. It shall publish and distribute the Journal. Reports, papers, and discussions may be submitted to this committee for publication in the Journal; but the committee shall have authority to curtail or abstract, or to return to the author, such material as seems to it unsuitable for publication, with a statement of the reasons therefor.

Section 15 — Committee on Medical Student Loan Fund

(a) The Medical Student Loan Fund of this Society—established by the House of Delegates at the 190th Annual Meeting, May, 1955—shall be administered by a committee of not more than five (5) members appointed by the President for terms of three (3) years. Their terms shall be so arranged that not more than two (2) expire at each annual meeting.

(b) It is the function of the committee to administer the Student Loan Fund program in accordance with the rules and regulations formulated by the committee and approved by the Board of Trustees.

Adopted (page 478)

Section 16 — Committee on Publication

(a) The Committee on Publication shall consist of three (3) members elected by the House of Delegates. Their terms shall be for three (3) years, so arranged that at each annual meeting the term of one (1) member expires.

(b) The committee shall be responsible for the publication and distribution of *The Journal*. It is empowered to edit or abstract all articles submitted for publication. Rejected articles shall be returned to their authors, with a statement of the reasons for rejection.

(c) The President-Elect, the Secretary, and the Editor of *The Journal* shall be members, ex-officio, of the Committee on Publication.

Adopted (page 478)

Section 17 — Committee on Revision of Constitution and Bylaws

(a) The Committee on Revision of Constitution and Bylaws shall consist of six (6) members appointed by the President for terms of three (3) years, so arranged that at each annual meeting the terms of two (2) members expire.

(b) The committee shall be responsible for preparing and/or evaluating proposed revisions to the Constitution and/or Bylaws, and for properly submitting them to the House of Delegates.

(c) The Secretary shall be a member, ex-officio, of the committee.

Adopted (page 478)

Section 12 — Advisory Committee to Woman's Auxiliary

(a) The Advisory Committee to the Woman's Auxiliary shall consist of five members. It shall at all times be cognizant of the activities of the Woman's Auxiliary and shall be the official liaison body between the Auxiliary and the Medical Society. It shall act as an advisory body in answering questions submitted to it by the Auxiliary, and shall be responsible for explaining the policy and programs of the Medical Society in matters pertaining to the Auxiliary.

(b) It shall receive and consider suggestions from the Auxiliary for activities in which the Auxiliary might assist the Medical Society.

(c) It shall make frequent reports on the Auxiliary's activities to the Trustees, and an annual report to the House of Delegates.

(d) It shall ascertain the need for funds by the Auxiliary and shall have supervision over the expenditure of such funds appropriated by the Society.

(e) This Committee shall recognize the close relationship between the activities of the Auxiliary in matters pertaining to the policy and programs of the Medical Society and the activities of the committee of the Medical Society having jurisdiction over such activities. Therefore, any program of the Auxiliary in this connection shall be sponsored by that committee of the Medical Society whose duty it is to deal with that particular activity, and after approval by the Board of Trustees, shall be financed within the limitations of the budget allotted to that particular committee.

(f) This Committee shall recognize that an important function of the Woman's Auxiliary is to act as hostess at the Annual Meeting of the Society and to the Auxiliary of the American Medical Association when it meets in New Jersey, and that no other activities of the Auxiliary shall detract from this function.

Section 18 — Advisory Committee to the Woman's Auxiliary

(a) The Advisory Committee to the Woman's Auxiliary shall consist of six (6) members, three (3) of whom shall be elected by the House of Delegates, and three (3) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of one (1) elected and one (1) appointed member expire.

(b) The committee shall have the responsibility to evaluate, coordinate, and guide the Woman's Auxiliary to The Medical Society of New Jersey in all its interests and activities, subject to approval by the Board of Trustees.

Adopted (page 478)

Section 16 — Special Committees

Special committees may be created by the House of Delegates or by the Board of Trustees. They shall be appointed by the President, or the Chairman of the Board of Trustees, and their specific functions and term of life shall be clearly defined. The limitations

Section 19 — Special Committees

(a) Special committees may be created by the House of Delegates or by the Board of Trustees.

(b) They shall be appointed by the President or the Chairman of the Board of Trustees.

in regard to incurring expense provided for in Chapter III, Section 2, of these By-Laws shall apply also to these committees.

Section 13 — Reference Committees

A. Prior to or immediately after the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measure or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, and hear debate thereon by any interested member of the Society.

B. 1. The Reference Committee may recommend approval or disapproval of the matter which has been referred to it by a majority vote.

2. A member of a reference committee, who wishes to make a minority report must refrain from signing the majority committee report and must make his intention known to the other members of the reference committee while it is in executive session and prior to the presentation of the majority report to the House of Delegates.

C. The Reference Committee may not recommend changes, additions, or rephrasing that would alter the original subject or intent of the matter which has been referred to it.

D. The Reference Committee may recommend changes, additions or rephrasing of the matter which has been referred to it that would clarify and accomplish the obvious intent of the referred matter.

(c) Their specific functions and duration shall be clearly defined.

Adopted (page 478)

Section 20 — Reference Committees

(a) Prior to, or immediately after, the organization of the House of Delegates at each annual meeting, the President shall appoint reference committees of five (5) members each, unless he deems a larger committee appropriate.

(b) In accordance with Chapter IX, Section 2(b) of these Bylaws, only members of the House of Delegates shall be eligible for membership on a reference committee.

(c) There shall be a Reference Committee on Credentials—to consist of one (1) member to serve with the Secretary and Treasurer; a Reference Committee on Constitution and Bylaws; and up to eight (8) others, as may be required, identified by letters A through H.

(d) To these committees shall be referred all reports, resolutions, measures, or propositions presented to the House of Delegates and not reserved by it for direct consideration.

(e) Each committee shall meet forthwith to consider the item or items referred and to hear discussion thereon by any interested member of this Society.

(f) By majority vote the committee may recommend approval or disapproval of any item or items referred to it. A committee member who wishes to make a minority report must refrain from signing the majority report, and must make his intention known to the other committee members while the committee is in session and prior to the presentation of the majority report to the House of Delegates.

(DELETE; included in next paragraph)

(g) A reference committee may recommend deletions, additions, or rephrasings to clarify and accomplish the obvious intent of the referred item, but it may not make changes which will alter the original substance or intent of the referred item. However, it may,

E. The report of the Reference Committee shall be submitted to the House of Delegates for action at the third meeting of the House of Delegates. Any changes, additions, or rephrasing recommended by the Reference Committee must be submitted to the House of Delegates as amendments to the referred matter and for approval must receive a majority affirmative vote by the members present at the meeting of the House of Delegates, except in the instance of amendments to the Constitution and By-Laws, when a two-thirds affirmative vote shall be required for approval.

F. Amendments to the report of the Reference Committee or to the report of proposed amendments to the Constitution or By-Laws may be introduced by any delegate from the floor at the time of consideration of the report of the Reference Committee except that amendments to the report proposed by the Reference Committee shall take precedence and be voted on first. To become effective, the amendment must be approved by a majority affirmative vote of the delegates present at the meeting except in instances of amendments proposed to amendments to the Constitution and By-Laws when a two-third affirmative vote is required.

Section 15 — Continuance of Function

On the order of the President or House of Delegates any reference committee may be created a special committee in order to continue, after the annual meeting, work which has been initiated but which cannot be completed during that meeting; but there shall be a strict limitation, in the order for its continuance, as to its function and term of life.

Section 14 — Names of Reference Committees

There shall be the following Reference Committees, and any others to be created by the House of Delegates as need arises:

(a) Credentials—to consist of one member to serve with the Secretary and the Treasurer, who are members ex-officio.

at its discretion, recommend an alternate version embracing the views of the reference committee for the consideration of and action by the House of Delegates.

(h) The committee report shall be submitted for action at the final session of the House of Delegates. Any deletions, additions, or rephrasings recommended by the reference committee must be identified as amendments to the referred items. For approval, such amendments must receive a majority affirmative vote by the delegates present and voting, except in the instance of amendments to amendments to the Constitution and Bylaws, which require a two-thirds (2/3) affirmative vote.

(i) Amendments to the report of a reference committee may be introduced by any delegate from the floor at the time of consideration of the report of the reference committee. However, amendments proposed by the reference committee shall take precedence and be voted on first. For adoption, amendments from the floor must receive a majority affirmative vote of the delegates present and voting, except in the instance of amendments to amendments to the Constitution and Bylaws, which require a two-thirds (2/3) affirmative vote.

(j) On the order of the House of Delegates any reference committee may be constituted a special committee in order to continue, after the annual meeting, work which has been initiated but which cannot be completed during that meeting; but there shall be a strict limitation, in the order effecting such continuance, as to the committee's function and duration.

Adopted (page 478)

Chapter IX as a whole—Adopted (page 478)

(DELETE; covered in Section 20 (c))

(b) Resolutions and Memorials.
(c) Constitution and By-Laws.
(d) Miscellaneous Business.

Section 17—Adding to Size of Committee

The President may at any time, on request of any committee, appoint additional members thereto, in order to meet unexpected or unusual demands on that committee; provided that the term of such emergency appointees shall cease with the close of the next annual meeting of the society.

(DELETE; unnecessary)

CHAPTER IX—FINANCE

Section 1 — Permanent Fund

(a) There is hereby established in the custody of the Treasurer a Permanent Capital Fund, to consist of any money which may come to The Medical Society of New Jersey by gift or bequest and not otherwise designated, any balance remaining unexpended at the close of the fiscal year which the Board of Trustees may direct to be added to this fund, and such other money as may from time to time be available for this purpose.

(b) This fund shall be deposited or invested by the Treasurer in such manner as is by law provided for trust funds, or as the Board of Trustees may direct. The income from such funds may be used for the general purposes of the society, unless otherwise ordered, but the principal of the fund may be expended only for purposes of permanent value to The Medical Society of New Jersey, when so ordered by a two-thirds vote of the House of Delegates, such expenditure having previously been approved by the Board of Trustees and notice of such approval sent to the component societies at least one month in advance of the meeting of the House of Delegates at which action is taken.

Section 2 — General Fund

(a) Annual Assessment of Members. On the first day of January in each year there shall be levied on each component society a per capita assessment on the membership of such component society, as hereinafter set forth (par. b), to be paid to the Treasurer of The Medical Society of New Jersey not later than five days before the first day of March, together with a list of the members for whom such payment is made. A similar per capita assessment shall be paid in the same manner immediately upon the admission or reinstate-

CHAPTER X—FINANCE

(DELETE. Permanent Capital Fund abolished by the House of Delegates in 1957 when the money in the fund was authorized to be used for the purposes of the Medical Student Loan Fund.)

(DELETE)

Section 1 — Annual Assessment

(a) By the first day of January in each year, each component society shall be officially informed of the per capita assessment levied by the House of Delegates. Payment of this assessment shall be forwarded to the Treasurer of this Society not later than five (5) days before the first of March, together with a list of the members for whom such payment is made.

(b) Per capita assessments shall apply in

ment of any member except that for a new member admitted after October 1 of any calendar year, one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as a subscriber to and entitled to receive the Journal.

No assessment shall be levied against any member in good standing if (a) he shall have attained the age of 70 years, or (b) he is serving with the armed forces of the United States, or (c) he is exempted by the component society from the payment of annual dues for financial reasons, such exemption to be reviewed annually by The Medical Society of New Jersey, or (d) he is a member emeritus.

If a member has not paid his dues by June 1, his name shall be dropped from the membership rolls.

the same manner immediately upon the admission or reinstatement of members, except that for a new member admitted after September first of any calendar year, only one-half (½) of the regular per capita assessment shall be levied. Every member for whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.

(DELETE; covered in (e))

(c) If a member has not paid his annual assessment by June first, his name shall be dropped from the membership rolls.

(The next paragraph is from the old Bylaws, Chapter I, Section 5(b), before the revision of 1958—deleted there for inclusion here)

(d) The annual assessment of a component society shall not be less than the per capita assessment of at least ten (10) members, the smallest number to whom a charter may be granted to form a component society.

(e) This assessment shall not be levied against any member in good standing if:

(1) he shall have attained the age of seventy (70) years; or

(2) he is serving with the armed forces of the United States; or

(3) he is a member emeritus; or

(4) the payment of the assessment would be a financial hardship by reason of physical disability or illness. A member may also be excused from payment of the assessment because of financial hardship for other reasons, but these reasons must be set forth annually by the secretary of the member's component society.

Adopted (page 478)

(b) Estimating the Assessment. Two weeks before the annual meeting each officer and standing committee shall send to the Chairman of the Committee on Finance an estimate of the amount of money necessary for the work of his office during the next fiscal year. The Committee on Finance shall then proceed to consider and determine the amount of money to be raised, fix the per capita assessment to be levied on the component societies, and report its recommendations to the House of Delegates at the first session of that body. This report may then be approved, amended, or rejected by the House of Delegates, but final action on it shall not be taken before the last session of the meeting.

(c) The Budget. No officer or committee may spend more money than the amount allowed in the budget without approval of the Committee on Finance, which may, however, apportion to such officer or committee, on application, any unexpended balance of other items; provided that the total amount disposed of by the Finance Committee must not exceed the total amount voted by the House of Delegates, unless by special authority of the Board of Trustees.

Section 3 — Fiscal Year

The fiscal year of the society shall begin on the first day of June, and the financial report of the Treasurer and of all officers and committees shall be for this period. The budget estimates and appropriations shall likewise be for the same period.

Section 4 — Budgets

All motions and resolutions appropriating money for special purposes shall fix a definite

Section 2 — Per Capita Assessment

(a) At the call of the chairman of the Committee on Finance and Budget, officers and committee chairmen shall submit an itemized estimate of the amount of money necessary for their official or committee's activities during the next fiscal year.

(b) The Committee on Finance and Budget shall then proceed to consider and determine the amount of money to be raised by the per capita assessment to be levied on the component societies.

(c) The recommendations of the Committee on Finance and Budget shall be reported to the House of Delegates at the first session of that body, together with any recommendations of the Board of Trustees after review.

(d) The House of Delegates may approve, amend, or reject the report, but final action on it shall not be taken until the last session of that body.

Adopted (page 478)

Section 3 — Annual Budget

(a) No officer or committee may spend more money than the amount allowed in the budget. The Board of Trustees may, however, apportion to any officer or committee, on application, any unexpended balance from others items, provided that the total annual budget voted by the House of Delegates is not thereby exceeded.

(b) The Board of Trustees shall have the power to authorize the expenditure of funds in excess of budgetary appropriations in accordance with the provisions of Chapter VI, Section 5.

Adopted (page 478)

Section 4 — Fiscal Year

The fiscal year of this Society shall extend from the first day of June through the thirty-first day of May. The audit report, budget estimates, and appropriations shall likewise be for the same period.

Adopted (page 478)

Chapter X as a whole—Adopted (page 478)

(DELETE; unnecessary)

sum, and shall state the budget account against which the expenditure is to be charged. Such resolution must be passed by the House of Delegates and approved by the Board of Trustees.

CHAPTER X—COMPONENT SOCIETIES

Section 1 — Charters

County medical societies of this state that shall adopt the principles of organization in accord with the Constitution and By-Laws of this society may, upon application to the House of Delegates, receive a charter, and thereby become a component society in affiliation with The Medical Society of New Jersey as hereinafter provided.

Section 2 — Conditions of Chartering

Charters shall be issued to county societies having at least ten members, under seal of The Medical Society of New Jersey and signed by the President and Secretary; but there shall be only one component society chartered in each county. Upon recommendation of the Board of Trustees, this society may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and By-Laws.

Section 3 — Qualifications of Members

(a) Judging Qualifications. Each component society shall be the judge of the qualifications of its own members, subject to the right of approval of this society; but, as such societies are the only portals to this society and to the American Medical Association, it is recommended that every reputable and legally registered physician shall be deemed eligible to membership in a component society.

CHAPTER XI—COMPONENT SOCIETIES

Section 1 — Charters

(a) County medical societies of this State that shall adopt principles of organization in accord with the Constitution and Bylaws of this Society may, upon application to the House of Delegates, be granted a charter, and thereby become a component society in affiliation with The Medical Society of New Jersey as hereinafter provided.

(b) Charters may be issued, under the seal of this Society and signed by the President and the Secretary, to county societies having at least ten (10) members. There shall be only one component society chartered in each county. Upon recommendation of the Judicial Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws.

Adopted (page 478)

Section 2 — Qualifications of Members

(a) Each component society shall judge the qualifications of its applicants for membership, but election to any type of membership shall be contingent upon review and approval by the Committee on Credentials of this Society.

(b) To be eligible for membership, the applicant must:

(1) be a citizen of the United States;

(2) hold a degree of Doctor of Medicine acceptable to this Society obtained from a medical school approved by this Society at the time of his graduation;

Amended to read:
(2) hold a degree in medicine . . .

(3) be fully licensed as a physician and surgeon by the New Jersey State Board of Medical Examiners;

Amended to read:
(3) be fully licensed to practice medicine and surgery by . . .

(4) be legally registered under that license in a county of New Jersey;

(5) be of good moral and ethical standing; and

(6) not support, or practice or claim to practice any exclusive system of medicine.

(b) Biographies of New Members. When a physician applies for membership or when an application is made to be received on transfer, the secretary of the component society shall forward his name and address to the biographic department of the American Medical Association for such information as may be on file relative to his record. Printed forms for this purpose will be furnished by the Secretary of this society. After the adoption of these By-Laws, no new member shall be enrolled or accepted on transfer until this provision shall have been carried into effect.

(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the biographic department of the American Medical Association for such information as may be on file relative to the applicant's record.

(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials.

Adopted as amended (page 478)

(c) Probationary and Associate Members.

(DELETE here; covered in Section 4)

(d) (Explantory note.—The following resolution defining courtesy members was passed by the House of Delegates, April 29, 1937: "Associate members of component societies shall be physicians who may be elected to active membership after a period of probation. All others now called associate members shall be termed courtesy members." Transactions, 1937, page 50.)

(DELETE)

Section 4 — Transfers

When a member in good standing in a component society moves to another county of this state, his name, upon request, may, by a majority vote of those present, be transferred to the roster of the component society into whose jurisdiction he moves.

Section 3 — Transfers

An applicant for membership by transfer who holds membership in a component society in this or another state society and whose credentials have been formally approved may be elected to membership without a probationary period, at the discretion of the component society.

Adopted (page 478)

(c) Probationary and Associate Members. Each component society as a requisite of eligibility to active membership, may require applicants to serve a probationary period of not longer than two years in the society as associate members. Associate members shall have such privileges in component societies as the Constitution and By-Laws of the respective societies may provide, except the right to vote

Section 4 — Associate Members

(a) Except in the case of transferred membership, each component society must require applicants to serve a probationary period of one (1) to two (2) years as associate members

(b) Associate members shall have such privileges in component societies as the Con-

and hold office. Their dues shall be those fixed by their respective component society, plus the subscription price of the Journal as determined by the Board of Trustees.

stitution and Bylaws of the respective societies may provide, except the right to vote and hold office.

(c) Associate members shall be assessed one-third (1/3) of the current per capita assessment, which shall be imposed to cover the cost of such publications as may be issued by this Society for its members.

Adopted (page 478)

Section 5 — Jurisdiction

Any physician living on or near a county line may hold his membership in the component society most convenient for him to attend, on permission from the component society in whose jurisdiction he resides; provided that no physician may be a member of two component societies at the same time, nor of this society and another state society.

Section 5 — Jurisdiction

(a) Ordinarily a physician will hold membership in the component society of the county in which he practices. However, with the permission of that component society, he may for reasons of convenience be a member of some other component society.

(b) No physician may be a member of two (2) component societies at the same time.

Adopted (page 478)

Section 6 — Reporters

Each component society shall elect a reporter, who shall furnish the Editor with brief reports of its meetings and of items of interest concerning the society and its members, extracts of papers and interesting case reports, notice of the prevalence of contagious and other diseases in the county, and the election, removal or death of members.

Section 6 — Reporters

Each component society shall elect a reporter, who shall furnish the Editor of *The Journal* with brief reports of its meetings and significant activities.

Adopted (page 478)

Chapter XI—Adopted as amended (page 478)

CHAPTER XI—RESIGNATION OR REMOVAL OF OFFICERS

Any officer of this society may resign his office, or he may be removed therefrom by a two-thirds vote of the House of Delegates, when guilty of neglect of duty, improper conduct, or upon violation of the Constitution and By-Laws. In either or all cases the society shall fill the vacancy so made as provided for in Article IX of the Constitution, and in Chapters V and VI of the By-Laws.

(DELETE; included in Chapter VI, Section 8)

CHAPTER XII — RULES OF CONDUCT

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of the members of The Medical Society of New Jersey in their relations to each other and to the public.

(DELETE; included in Chapter I, Section 4)

CHAPTER XIII — RULES OF ORDER

(DELETE; included in Chapter II, Section 3)

The deliberations of the society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order," when not in conflict with this Constitution and By-Laws, unless otherwise determined by a two-thirds vote of its respective bodies.

CHAPTER XIV—CONFERRING THE DEGREE OF DOCTOR OF MEDICINE

(DELETE as Chapter of the Bylaws; retain as an addendum for historical record.)

Candidates for the degree of Medicinae Doctor may apply to any component society of this state, and shall be admitted to examination under the following rules and regulations:

First. Each component society shall appoint annually, or pro re nata, a committee of not less than five members, who shall conduct the examinations.

Second. All examinations shall be in the presence of The Medical Society of New Jersey at a regular meeting; and no candidate shall be examined until he has given satisfactory evidence of having reached the age of twenty-one years, is of good moral character, that his preliminary education has been such as to qualify him for the study and practice of medicine, and has pursued his medical studies in some medical college whose requirements do not fall below the minimum standard of the Association of American Medical Colleges.

Third. The examination shall extend to all of the branches taught in the medical schools recognized as aforesaid; and the candidate shall then be balloted for by The Medical Society of New Jersey. If he shall receive the approving votes of two-thirds of all the members present, the presiding officer shall give a certificate to that effect to the candidate.

Fourth. The certificate may be presented at the next or any subsequent regular meeting of The Medical Society of New Jersey, not extending beyond the period of three years, with a written thesis upon some medical subject; and if, upon a ballot, he shall be approved by a majority of the members present, the candidate, upon the payment of fifteen dollars, shall be entitled to receive a diploma in the following form:

This will certify that we ..... censors of the District Medical Society for the County of ..... appointed by The Medical Society of New Jersey, have this day carefully and impartially examined ..... of ..... county of ..... state of ..... and being well satisfied with his attainments in the various branches of Medical and Surgical Science and of his

moral character do recommend him to the president of The Medical Society of New Jersey as a proper person to receive a license to practice physic and surgery throughout the state of New Jersey.

CHAPTER XV—AMENDMENTS

These By-Laws may be amended at any annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day.

Upon the adoption of this Constitution and these By-Laws all previous Constitutions and By-Laws are thereby repealed.

CHAPTER XII—AMENDMENTS TO THE BYLAWS

These Bylaws may be amended in the following manner:

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

3. Study of the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws.

4. Submission of the proposed amendment in writing at the first session of the House of Delegates.

5. Report on the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws at the first session of the House of Delegates.

6. Referral of the proposed amendment and report thereon to the appropriate reference committee.

7. Hearings on the proposed amendment and report thereon by the reference committee.

8. Report of the reference committee to the final session of the House of Delegates for appropriate action.

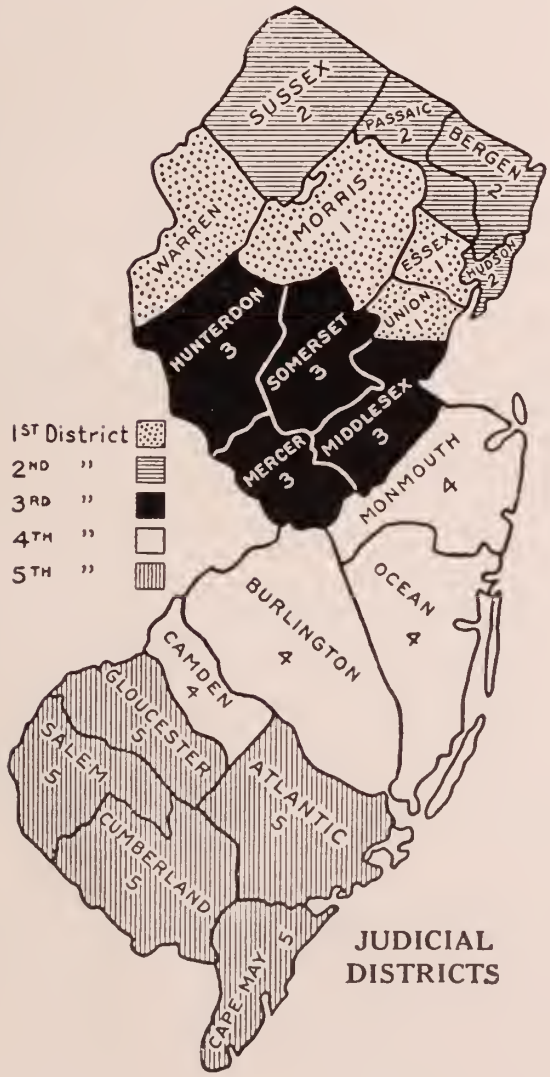
9. Adoption by a two-thirds (2/3) vote of the members of the House of Delegates present and voting at the final session.

Chapter XII—Adopted (page 478)

Note:

In accordance with the provision of Article VII of the Constitution—(The House of Delegates shall organize five (5) councilor districts within the State.)—

the following division of the State into judicial districts was made by the House of Delegates at the 1917 annual meeting. It is still in effect (1959).



Nominations for Emeritus Membership

(Reference Committee on Resolutions and Memorials)

The following nominations for election to emeritus membership at the 1959 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

BERGEN COUNTY

Clarence A. Connor, Fort Lee: age 73

Charles B. Warren, Ogdensburg, N. Y. (formerly Bergenfield); age 75
William C. Williams, Rutherford; age 75

ESSEX COUNTY

Julius Bernstein, North Miami, Fla. (formerly Newark); age 63
LeRoy Colsh, Bay Head: age 70
Haynes H. Fellows, Maplewood; age 68
E. Zeh Hawkes, Newark; age 94
George J. Holmes, Summit; age 82

UNION COUNTY

James G. Boyes, South Plainfield; age 65
E. Hugh Doggett, Plainfield; age 68

Adopted (page 477)

RESOLUTIONS

Voluntary Association Between Physicians and Optometrists

(Reference Committee "A")

From the Essex County Medical Society

Whereas, the House of Delegates of the AMA approved the Report of its Judicial Council, December 1955, declaring voluntary associations with optometrists unethical, and

Whereas, the AMA House of Delegates in 1956 directed that its action be communicated to all constituent state associations, and

Whereas, the AMA Judicial Council has reaffirmed this position in the "Opinions and Reports of the Judicial Council, 1957"; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey endorse the action of the AMA House of Delegates and the interpretations of the AMA Judicial Council, and that this action be communicated to the component medical societies for the information and guidance of their members individually and of the county societies.

Rejected. By the adoption in 1955 of Resolution No. 77, this tenet was incorporated as of that time into the Code of Ethics of the American Medical Association.
Inasmuch as Chapter I, Section 4, of the Bylaws of The Medical Society of New Jersey declares: "The 'Principles of Medical Ethics' adopted by the American Medical Association shall govern the conduct of members in all categories of The Medical Society of New Jersey in their relations to each other and to the public," this Society's endorsement of the ethical tenet involved was automatic and immediate. No further action is in order. (page 471)

Budgetary Allotment for Medical Service Administration

(Reference Committee "B")

From Medical Service Administration of New Jersey

Whereas, Medical Service Administration of New Jersey is an important agency serving The Medical Society of New Jersey in the field of distribution of medical care, and

Whereas, new programs of medical care for the indigent and medically indigent persons and for the elderly, may need an agency for their implementation, and

Whereas, the programs presently conducted by the Administration yield only a small or no monetary profit, and

Whereas, the usual annual net income through the Administration is insufficient to keep the Administration actively in being; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey, at its annual convention, April 25, 1959, through April 29, 1959, authorize the sum of five thousand dollars ($5,000) for inclusion in the budget annually to be made available to Medical Service Administration of New Jersey if and when needed; and be it further

Resolved, that copies of this resolution be referred to the respective reference committees which will consider the report of Medical Service Administration of New Jersey and the report of the Finance and Budget Committee.

Disapproved. Reference committee recommendation that should urgent financial need arise in the future, specific requests should be submitted to the Board of Trustees—Adopted (page 472)

Health Care of the Aged

(Reference Committee "C")

From the Bergen County Medical Society

Whereas, the medical care of the aged is becoming an ever increasing problem, and

Whereas, such care of the aged should be the concern of every physician, and

Whereas, the medical profession must endeavor to include the care of the aged within the structure of private practice, as contrasted to government subsidy and control, and

Whereas, the Bergen County Medical Society, at its regular meeting on March 10, 1959, formally adopted this resolution; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey go on record as favoring the A.M.A. suggestion to formulate a Blue Shield Plan for medical care of our senior citizens with limited means, whereby premiums paid by these citizens would be scaled downward, and fees to physicians proportionately reduced.

Recommitted (page 473)

Medical-Surgical Plan—X-Ray Diagnostic Services

(Reference Committee "C")

From William L. Palazzo, M.D., Delegate from Bergen County

Whereas, the Medical-Surgical Plan of New Jersey has been granted permission by the State Insurance Commission to offer several riders for extended coverage, and

Whereas, one of these riders provides for payment for x-ray diagnostic services outside of the hospital, and

Whereas, the welfare of the individual patient, and protection of his health, should be the concern of the medical profession, and

Whereas, the promiscuous use of x-ray would endanger the patient's health, and also be a financial burden to Blue Shield; therefore be it

Resolved, that the Medical-Surgical Plan of New Jersey use discretion in formulating its plan of payment for x-ray diagnostic services. This could be done simply by excluding payment to physicians for self-referred x-ray examinations.

Disapproved (page 474)

Paid-Up Policies in Blue Cross-Blue Shield

(Reference Committee "C")

From the Mercer County Medical Society

Whereas, the aged are increasing proportionately in our population; and

Whereas, The Medical Society of New Jersey has recently circulated its membership relative to reduced fees, under the Blue Shield Plan for care of the aged; and

Whereas, there has been introduced, Federal legislation (the Forand Bill) for the care of the aged through general taxation; therefore be it

Resolved, that The Medical Society of New Jersey investigate, or instruct the Blue Cross-Blue Shield Plans to investigate the possibility of a withholding premium that would enable a subscriber to obtain paid-up Blue Cross-Blue Shield policies upon retirement.

Adopted (page 474)

Hypnosis

(Reference Committee "E")

From the Ocean County Medical Society

Whereas, utilization of hypnosis as a treatment modality is a potent form of therapeutic intervention; and

Whereas, its injudicious use may evoke considerable emotional volatility which may cause untoward effects and thus be detrimental to the mental health of the subject; therefore be it

Resolved, that a committee of The Medical Society of New Jersey be appointed to study the problem of entertainment hypnosis and whether or not its practice should be prohibited by law in the State of New Jersey.

Adopted (page 476)

Optometrists and Drugs

(Reference Committee "E")

From the Cumberland County Medical Society

Whereas, there is evidence of the use of drugs by optometrists, and of other acts by optometrists beyond the legal definition of optometry; therefore be it

Resolved, that it is the position of The Medical Society of New Jersey that the use of drugs in any form by an optometrist is against the public interest and constitutes the illegal practice of medicine, and be it further

Resolved, that the Society use every means at its disposal to bring about the prosecution and conviction of optometrists who use drugs or otherwise engage in the illegal practice of medicine, and to bring about such strengthening of the Medical Practice Act and clarification of the Optometric Act as may be necessary; and that a thorough study of the Medical Practice Act and Optometric Act be undertaken to this end.

Adopted (page 476)

Optometrists—Contact Lenses and Drugs

(Reference Committee "E")

From the Essex County Medical Society

Whereas, the fitting of contact lenses is a medical function, and

Whereas, there is today ample evidence that non-medical personnel are fitting contact lenses without the benefit of medical supervision, and

Whereas, there is evidence that non-medical personnel are using drugs such as local anesthetics, staining solutions such as Fluorescein, and proprietary medications as "soothing agents," and

Whereas, in the opinion of the Conservation of Vision Committee of the Essex County Medical Society such use of drugs is in violation of the Medical Practice Act; therefore be it

Resolved, that the County Committee condemn this practice and recommend that steps be taken to end it; that this matter be brought to the attention of The Medical Society of New Jersey; and that this resolution be forwarded to the other component medical societies.

Adopted (page 476)

Rehabilitation Services Directory

(Reference Committee "E")

From Mercer, Burlington, and Somerset County Medical Societies

Whereas, the Special Committee on Rehabilitation of The Medical Society of New Jersey believes that the average physician is unaware of the existence of local rehabilitation and services and therefore does not utilize them to their fullest extent and facilities, and

Whereas, the Special Committee on Rehabilitation of The Medical Society of New Jersey believes that the compilation and publication of a directory of such information on a

County and State basis should be undertaken, and

Whereas, the services of trained personnel to insure proper and uniform compilation of this material can be made available through private, philanthropic, or government funds; therefore be it

Resolved, that The Medical Society of New Jersey take such steps as may be necessary to develop this project with all expediency.

Adopted (page 476)

Social Security for Physicians

(Reference Committee "E")

From the Bergen County Medical Society

Whereas, several component societies of The Medical Society of New Jersey have determined by recent polls that the majority of their members desire to be included under the provisions of Social Security, and

Whereas, several constituent societies of the American Medical Association have gone on record favoring such inclusion for their members; now therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey at its 193rd annual meeting go on record as favoring the inclusion of the members of The Medical Society of New Jersey under the provisions of Social Security; and be it further

Resolved, that the wishes of the members of The Medical Society of New Jersey regarding Social Security coverage, as determined by the House of Delegates, be transmitted formally to the American Medical Association at its Annual Meeting in June, 1959.

Adopted (page 476)

Social Security for Physicians

(Reference Committee "E")

From the Essex County Medical Society

Whereas, the Essex County Medical Society, in February 1959, polled its 1630 members, asking whether or not they favored "Compulsory Social Security for Physicians," and

Whereas, 1267 of these questionnaires were returned, thereby showing a tremendous physician interest in this subject, and

Whereas, 865 of the 1267 returns were in favor of such inclusion under social security (392 opposed and 10 undecided), and

Whereas, this is better than two to one now in favor of this coverage, and

Whereas, other surveys of physicians indicate that there is a growing national trend among doctors to want to be included in social security, and

Whereas, clergy, dentists, and attorneys were included, in recent years, in social security, and

Whereas, we are the only profession now not enrolled in social security; therefore be it

Resolved, by the Officers, Councilors, and members of the Essex County Medical Society, that The Medical Society of New Jersey be petitioned to instruct its Delegates to the AMA to work toward the goal of having physicians included under compulsory social security with the rest of the public and the other professions.

Adopted (page 476)

Social Security for Physicians

(Reference Committee "E")

From the Mercer County Medical Society

Whereas, the problem of coverage of individual physicians by Old Age and Survivors Insurance has again been brought to the attention of the Mercer County Component Medical Society; and

Whereas, a poll of the total membership of the society, in which 273 questionnaires were returned of 377 inquiries sent; and

Whereas, 174 answered YES to the question "Do you wish to be included in O.A.S.I.?" as opposed to 53, who answered NO, a majority of 7 to 2; therefore be it

Resolved, that the Delegates from Mercer County Component Medical Society be instructed to support any resolution offered at the House of Delegates of The Medical Society of New Jersey in 1959 which requires compulsory inclusion of the physicians in Old Age and Survivors Insurance; and be it further

Resolved, that the House of Delegates be requested to include this subject upon its agenda, if no prior request is on file.

Adopted (page 476)

Medical Service Administration of New Jersey

(Reference Committee "C")

THE BOARD OF GOVERNORS

During 1958 Medical Service Administration of New Jersey has been active in the operation of the City of Newark Medical Plan and the Medicare Program of the United States Government.

NEWARK MEDICAL PLAN

The Newark Medical Plan is designed to meet the needs of the indigent and the medically indigent of the City of Newark on a "cost plus," rather than on an insurance basis; it provides for medical services rendered in the homes of eligible persons by physicians of the patient's choice on a fee-for-service basis.

The Plan successfully demonstrates how the problem of public medical care of the indigent and medically indigent may be solved through the cooperation of an official health agency with a voluntary non-profit agency established by the medical profession.

Following are the statistics on number of cases and cost of services rendered during 1958 as compared to previous years.

The classification of *indigent* is applied to those persons whose names appear on the Welfare Rolls of the City of Newark; the *medically indigent* are those who are considered by the Social Service Bureau of the City Division of Health as having sufficient income to meet the routine of an adequate standard of living, but lack sufficient income to pay for needed medical care.

It will be noted that, although the mean number of persons on the Welfare Rolls was increased approximately 32 per cent in 1958, there was but slight increase in the number of relief clients receiving medical care. Explanation for this difference may be found in the sharp rise in relief cases occurring in the last month of the year; medical care for the added relief clients will be reflected in the 1959 report.

Altogether, the Plan has proceeded smoothly with no change in operation or policy the past year.

The Essex County Medical Society has cooperated by supplying new physicians to the panel available to service the needy of the City of Newark. Sixty physicians participated in the program during 1958.

INDIGENT (RELIEF) PERSONS

	Year			
	1955	1956	1957	1958
Mean number of persons on Welfare Rolls during year	5281	3883	4262	6626
Number of cases served	1964	1277	1556	1655
Value of approved services	$6,565.50	$4,605.00	$7,000.50	$7,630.00
Cost per capita of relief load	1.24	1.19	1.57	1.15
Cost per case per year	3.34	3.60	4.54	4.61

MEDICALLY INDIGENT CASES*

Number of cases* served during year	3335	2993	4291	3703
Value of approved services	$11,151.00	$9,969.00	$17,662.50	$15,420.00
Cost per case* per year	3.34	3.33	4.11	4.16

*The word "case" here means "family" as distinguished from "person" referred to under the report on number of "persons on Welfare Rolls" above.

MEDICARE PROGRAM

Medical Service Administration of New Jersey, as the Fiscal agent of The Medical Society of New Jersey, rounds out its second year of administering the physicians' portion of the Medical Care Program for dependents of members of the armed services which was implemented by the Department of the Army on December 7, 1956. Under this program, wives (or dependent husbands) and children of persons in military service are entitled to medical and surgical services from civilian physicians and hospitals at government expense.

We believe that the experiences of the first year of operation pointed the way to a smoother and more efficient system of handling claims, thereby obviating the main cause for complaints.

A review of the accomplishments of the Medicare Program in New Jersey since its initiation in December 1956 is presented herewith:

Two thousand and five New Jersey physicians received fees for services performed for beneficiaries of the Medicare Program during the year 1958, as compared with 1,675 during 1957.

At the end of the year 616 claims were in process of payment while 468 remained to be processed routinely. Of the claims paid in 1958 about 68 per cent were for maternity care, 18 per cent for pediatric care, 9 per cent were for surgical care and 5 per cent for miscellaneous illnesses and conditions.

ADMINISTRATIVE EXPENSE

Period	Amount	Per Case
Dec. 7/56-June 30/57	$19,670	$11.44
July 1/57-June 30/58	28,796	3.22
July 1/58-Dec. 31/58	21,649	4.70
Total	$70,115	4.59

CLAIM EXPERIENCE

Period	Received	Declined	Returned As Incomplete	Paid Claims	Paid Amount	On Hand
Dec. 7, 1956-Dec. 31, 1957	10,017	320	3,179	5,982	$489,265	536
Jan. 1, 1958-Dec. 31, 1958	14,014	377	3,758	9,298	778,551	1,084
Total	24,031	697	6,937	15,280	$1,267,816	1,085†

† Includes adjustments to agree with monthly inventories.

The above administrative expense data reflects the initial costs of the program (contract negotiations, printing, distribution of manuals, and training). The rise in the July 1, 1958—December 31, 1958 period also includes cost of printing and distributing the new fee schedule manuals, and information with respect to changes in the program effective October 1, 1958.

In New Jersey, Army dependents represented approximately 35 per cent of the total number of cases, the Navy about 33 per cent and the Air Force about 20 per cent. The Marine Corps, Coast Guard, Public Health Service and Coast Geodetic Survey—the remaining classes of those whose dependents are eligible for federal Medicare coverage—accounted for the remainder.

The substantial increase in number of cases covered and total benefits incurred, is credited in large measure to the increased awareness by servicemen of the program, which, in 1957 was relatively new.

There can be no doubt that the program has performed a useful service in providing medical and surgical care to dependents of members of the armed services.

Under date of July 1, 1958, The Medical Society of New Jersey and Medical Service Administration of New Jersey signed a Restatement Modification with the United States Government, Department of the Army, renewing the contract for the conduct of the Dependents' Medical Care Act, P. L. 569 in New Jersey to June 30, 1959.

Subsequently, Medical Service Administration, as Fiscal Administrator, renewed the subcontract with the Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the Prime Contract, which services are being performed in the name of Medical Service Administration.

Medical Service Administration of New Jersey obtains official signatures on all documents and is responsible for their proper transmission; reviews and advises Hospital Service Plan on all questionable claims involving status of physicians, application of the Fee Schedule, or medical practice; reviews correspondence between the Fiscal Administrator and the Special Medicare Committee and the Office for Dependents' Medical Care, and assigns members of its medical staff as required to perform these services.

Effective October 1, 1958, the Federal Government was compelled to modify the program because of congressional budgeting limitations and congressional demand for use of military facilities whenever possible. Two major changes reducing the scope of Medicare services have been ordered by the Secretary of Defense as follows:

CHANGE AREA 1. *Dependents residing with their sponsor* (the uniformed serviceman) will no longer have free choice of a civilian physician and/or hospital. Such dependents must *first* seek care from the nearest military facility. Should the appropriate military commander determine that needed care is not available at the military facility, he will advise the dependent to seek care from civilian sources, and will issue the dependent a *permit*.

CHANGE AREA 2. The type of care authorized in civilian hospitals will be curtailed. Restrictions have been placed on the particular medical conditions for which care may be provided at government expense.

I—No out-patient care for medical or surgical conditions will be payable, including emergency care. (pre-natal and post-natal out-patient services continue to be a benefit)

II—*No* care will be payable for *acute emotional disorders*, except as incidental to care of an acceptable acute medical or surgical condition.

III—No payment will be made for elective care; that is, "Medical or surgical care desired or requested by the patient which, in the opinion of the cognizant medical authority, can be planned, subsequently scheduled, and effectively treated at a latter date without detriment to the patient . . ."

Authorized care *without* a Medicare *Permit* to a dependent living with sponsor is permitted in acute emergencies requiring immediate hospitalization, or if the dependent is on a trip and requires hospitalization; or for maternity cases past the 15th week of pregnancy and under a civilian physician's care before October 1, 1958.

A Medicare permit is not required from dependents residing apart from their sponsors. Such dependents may choose between civilian sources of medical care and military sources, provided the benefits are authorized under the program.

Among the benefits discontinued were certain out-patient services and surgical conditions not of an emergency nature requiring immediate hospitalization. *Exceptions* are pre-natal and post-natal care, services required by an infant born outside the hospital but not

beyond a period of 10 days following birth, and x-ray therapy started or prescribed during hospitalization following in-patient hospitalization for malignancy. Although elective surgery was not authorized under the program from its inception, surgery for such conditions as T & A or hernias, which were previously allowed, are no longer paid for by the Federal Government.

In line with the foregoing reduction in Medicare services, a new improved Schedule of Allowances was negotiated by the Special Medicare Committee of The Medical Society of New Jersey with the Department of the Army, which became effective November 1, 1958.

Although some services were curtailed, fees for many eligible services were increased; in no instance would an agreed upon fee be less than that provided by the Medical-Surgical Plan of New Jersey for a particular procedure.

Provisions have been made for adjustments that may occur when a physician believes he is entitled to a fee higher than that permitted under the Schedule of allowances. In such instances the physician is requested to submit a special report to Medical Service Administration, which report, in turn, is referred to the Special Medicare Committee of The Medical Society of New Jersey for review and recommendation. After careful review, the Committee's recommendation is then returned to Medical Service Administration, which, in due course, submits it with the physician's claim to the Federal Government for review and approval. The amount approved for payment to the physician is then paid by Medical Service Administration.

At this point, we again wish to commend the members of the Special Medicare Committee of The Medical Society of New Jersey for their conscientious consideration of each case submitted for review and recommendation; with but few exceptions, the Office for Dependents' Medical Care has concurred in the recommendations of the Committee.

In its operation of the City of Newark Medical Plan on a municipal level, and the Medicare Program on a Federal level, Medical Service Administration of New Jersey has demonstrated its importance and value as an organization through which medical and surgical care may, by arrangements with Governmental agencies at Federal, State or other levels, be made available to individuals and groups not eligible for insurance protection against illness on a non-profit voluntary prepayment basis, and is designed to preserve the patient-physician relationship and allow free choice of physician and patient.

The Board of Governors of Medical Service Administration of New Jersey again wishes to express to The Medical Society of New Jersey its appreciation of and thanks for the continued moral and financial support so generously given to the Administration during the eighteen years of its existence.

Adopted (page 474)

Medical-Surgical Plan of New Jersey

(Reference Committee "C")

ROYAL A. SCHAAF, M.D., President, Board of Trustees

This annual report accurately and graphically reflects the accomplishments of Medical-Surgical Plan, New Jersey's Blue Shield Plan, for 1958. As in all years preceding, this year too, the Plan has shown progress with promises of more to come. Coverage has been expanded, benefits to Subscribers increased and a large number of fees increased. These expansions are all to the good and are a most important development in view of the medical aspects of current socio-economic trends.

Perhaps one of the most outstanding events of the year was Medical-Surgical Plan's ability to effect a 5 per cent reduction in Subscribers' premium rates on October 1. This, coming in the midst of a spiralling inflationary economy —when prices for practically all other necessities continued to rise—made it all the more significant, and a subject for nationwide attention, as well. Of no less significance and effective concurrently with the reduced premium rates, was the approval by the Board of Trustees of an upward adjustment in the Schedule of Payments for many professional services, thereby providing greater benefits for subscribers and a more realistic return for the services of the medical profession.

In addition to increased fees for many surgical and anesthesia services, Medical-Surgical Plan, recognizing the need for broader service to medical patients and their doctors, also made generous increased payments for daily in-hospital medical care. In this connection, special consideration was given to the critically ill patient who requires unusual attention during the early stages of his illness, by providing even more benefits for the services of an attending and consulting physician rendered during the first three days of such an illness.

Toward the end of the year, in compliance with a recommendation of the A.M.A.—and endorsement by The Medical Society of New Jersey—that prepayment health coverage be made available for persons over 65 years of age with limited resources, Medical-Surgical Plan proceeded to develop a program for medical-surgical coverage of our Senior Citizens. Although many details are still being explored to promulgate a program that may be made available to persons over 65 years of age at reduced premium rates, it is my pleasure to report that satisfactory progress toward attaining this objective is being made by our staff.

Elsewhere in this report there is presented additional data which will indicate the progress made, and being made in many other projects which will be of interest to the members of The Medical Society of New Jersey, subscribers and the public at large.

In behalf of the Board of Trustees I wish to extend sincere thanks to our Participating Physicians without whose cooperation, loyalty and understanding the excellent results of this year would not have been possible; to the devoted efforts and the efficient conduct of our operating staff in dedicating themselves to the success of the Plan; and to the Hospital Service Plan of New Jersey for the excellent service and invaluable assistance which it continues to give in many matters concerning Medical-Surgical Plan.

NON-GROUP ENROLLMENT

. . . AN OPPORTUNITY FOR ALL!

The Plan, in 1950, had accepted a trial enrollment of a limited number of persons on a non-group basis for the purpose of studying its experience with that enrollment in order to formulate a permanent Contract and enrollment policy under which it might meet the acknowledged need for non-group enrollment. During 1957, Medical-Surgical Plan made available for the first time enrollment on a non-group basis to the entire population of New Jersey. This policy was continued during 1958.

What is the non-group population?

The non-group population refers to those segments of the population which are self-sustaining, who do not work for a common employer, or are employed in groups too small to be included in present-day group health insurance, under the prevailing insurance underwriting practices. The segments of the population which would then fall into the category of non-group are:

(1) The self-employed.

(2) Persons over a certain age.

(3) Employees too small in number to be covered under group contracts of local plans.

Organized 1942

MEDICAL-SURGICAL PLAN OF NEW JERSEY
COMPARATIVE STATEMENT
As of December 31

ASSETS

	1958	1957
Cash	$ 659,878	$ 767,278
Accounts Receivable—Subscriptions	461,069	564,161
Accounts Receivable—Hospital Service Plan	57,337	284,647
Accounts Receivable—Other	22,617	15,026
Accrued Interest Receivable	123,426	133,643
Investments	15,443,413	11,907,392
TOTAL ASSETS	$16,767,740	$13,672,147

LIABILITIES

Payable for Medical-Surgical Claims	$ 4,550,000	$ 3,750,000
Unearned Subscriptions	1,160,939	1,114,246
Other Liabilities	49,816	29,084
TOTAL LIABILITIES	$ 5,760,755	$ 4,893,330

RESERVES FOR THE PROTECTION OF SUBSCRIBERS

Securities Evaluation	$ 200,000	$ 100,000
Special Contingency	100,000	100,000
Unassigned	10,706,985	8,578,817
TOTAL RESERVES	$11,006,985	$ 8,778,817
TOTAL LIABILITIES AND RESERVES	$16,767,740	$13,672,147

Throughout 1958, an additional 11,533 non-group Subscription Contracts have been issued by the Plan. Adherence to strict underwriting regulations indicates that approximately 24 per cent of all applications received were declined because of health reasons, overage, non-residence, etc.

Following is summary of 1958 results:

Total applications approved for enrollment 11,533.

Total applications declined 3,872.

Health reasons, 2,441.

Non-Health reasons, 1,431.

ENROLLMENT GROWTH

In 1942 our enrollment was 4131. In 1958 it was 1,830,397. In specific years it was:

1942	4,131
1945	49,441
1948	236,604
1951	669,906
1954	1,196,804
1957	1,711,834
1958	1,830,397

CLAIMS INCURRED

In 1942 we incurred $5,395 in claims. Last year the figure exceeded $25,000,000. In selected years the claim record was:

1942	$ 5,395
1945	208,228
1948	1,203,652
1951	6,527,375
1954	13,991,592
1956	18,960,672
1957	22,886,253
1958	25,037,986

The claims-incidence per thousand persons is shown in the table below:

1942	40
1945	86
1948	96
1951	112
1954	126
1956	143
1957	157
1958	153

* Because of insufficient data of earlier years, average exposure for any year was of necessity defined as the average of the beginning and ending exposure of the year.

DISTRIBUTION PER DOLLAR OF INCOME

Cents	
43.6	Surgical
19.1	Obstetrical
14.2	Medical
8.2	Operating expenses
7.3	Anesthesia
6.2	Contribution to Reserves
1.4	Consultation
$1.00	

DISTRIBUTION OF LIABILITY

85.6%	to incurred claims
8.2%	to operating expenses
6.2%	contribution to reserves
100%	total liability incurred

INCURRED CLAIMS BASED ON PAID CLAIMS FOR 1958

Total Incurred 1958—$25,038,000.00 = 85.6%

Surgical	12,761,000.00 = 43.6
Medical	4,151,000.00 = 14.2
Obstetrical	5,583,000.00 = 19.1
Consultation	409,000.00 = 1.4
Anesthesia	2,134,000.00 = 7.3

Note 1: All lines shown in each table are mutually exclusive.

Note 2: Average payment for consultations and anesthesias are payment per service; payments for these services are not included in the table.

AVERAGE PAYMENT PER PRIMARY SERVICE (Service)—PAID 1958

Surgical	$ 76.98
Medical	64.54
Obstetrical	110.54
Consultation	(15.03)
Anesthesia	(21.60)

FIELD SERVICE PROGRAM

The activities of the Medical-Surgical Plan's field representatives increased somewhat in 1958 over those in 1957. A principal feature of this program has been a schedule of visits to general hospitals throughout the State and the establishment of an information desk at the hospital on the day on which the visit has been scheduled. The purpose of the program is primarily to provide information as to claim procedures and reporting requirements of the Plan and to assist physicians in solving problems arising in the course of their individual dealings with the Plan. To aid in the operation of this program, Dr. Harry N. Comando, retired Newark surgeon and former Plan Trustee, was appointed Physician Relations Director in May 1958.

In each county in which the work has been undertaken, there has been prior consultation and clearance with the Advisory Committee to Medical-Surgical Plan representing the local County Medical Society. The Representatives conduct informative sessions for physicians at community hospitals, they call upon physicians to answer their questions and provide information concerning Plan procedures, they present Plan information before hospital medical staff groups and generally, they assist physicians in their day-to-day relations with Medical-Surgical Plan patients.

During the past year, 19 counties were covered with visits to 66 hospitals within the counties covered. A total of 1,482 physicians were personally contacted during the hospital visits. In addition, 381 other personal contacts were made throughout the year.

A careful record is kept of the comments and suggestions registered by physicians at these sessions. The Plan is better informed concerning the current reaction of the physicians regarding the Plan's policies and procedures than ever before. The comments made by physicians and their office personnel relative to the value of this service have been very favor-

PAID IN 1958

	Primary Services	Total Services	% (All Services)	Payment	%
Surgical	160,521	190,135	43.3%	$12,357,222.12	51.0%
Medical	62,333	76,684	17.5	4,023,216.73	16.6
Obstetrical	48,847	50,517	11.5	5,399,621.22	22.3
Consultation	—	25,403	5.8	381,827.78	1.6
Anesthesia	—	96,098	21.9	2,076,098.29	8.5
TOTAL	271,701	438,837	100.0%	$24,237,986.14	100.0%

able—indicating a desirability of extending this service in order that understanding of the Plan may be enhanced throughout the profession.

The continuing aims of the Physician Relations Committee may be summarized as an attempt to develop suitable media and methods for broadening the scope of the Physician Relations Program in order to realize the following objectives:

1. To open up and utilize every conceivable medium of two-way communication between the Plan and the medical profession.
2. To better inform physicians and their office nurses and secretaries as to their function in the operation of the Plan.
3. To create a better informed attitude of understanding and cooperating among physicians with respect to the purposes, policies and problems of the Plan.
4. To create a conscious sense of co-partnership with the Plan among individual physicians in a keener sense of their own sponsorship of the Plan and of their participation in the ultimate direction of the Plan.
5. To ferret out grievances and constructive suggestions for improvement of the Plan among physicians
6. To build the Plan's list of Participating Physicians up to the maximum number and to convert every Participating Physician into a cooperating physician.

COMPARATIVE SUMMARY OF OPERATIONS

	1958		1957	
Subscriptions Earned	$29,228,537	100.0%	$27,900,952	100.0%
Less:				
Claims Incurred	$25,037,986	85.7	$22,886,254	82.0
Operating Expenses	2,382,649	8.2	2,401,044	8.6
	27,420,635	93.9	25,287,298	90.6
Gain from Underwriting Operations	$ 1,807,902	6.1%	$ 2,613,654	9.4%
Income on Investments	441,961		315,445	
Operating Gain for the Year	$ 2,249,863		$ 2,929,099	

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1	$ 8,778,817	$ 5,725,806
Operating Gain for the Year	2,249,863	2,929,099
	$11,028,680	$ 8,654,905
Plus: Change in Non-Admitted Assets	——	123,912
Less: Change in Non-Admitted Assets	21,695	——
Reserves at December 31	$11,006,985	$ 8,778,817

HIGHLIGHTS OF PLAN OPERATIONS 1958-1957

Subscriptions Earned by the Plan Increased in 1958 over 1957 by		$ 1,327,585
Subscribers Claims Incurred by the Plan Increased in 1958 over 1957 by		2,151,732
Operating Expenses Decreased in 1958 under 1957 by		18,395
In addition, based on Subscriptions Earned, 1958 showed a percentage decrease of		.4%
Reserves for the Protection of the Plan's Subscribers Increased in 1958 over 1957, as follows:		
Securities Evaluation	$ 100,000	
Unassigned	2,128,168	
		$ 2,228,168

NATIONAL ACCOUNTS

What is a national account?

Simply, it is a local account of a corporation that operates in one or more states throughout the nation and thus has groups of employees in areas covered by more than one Blue Shield Plan.

These national accounts have problems in their dealings with their employees in regard to health care protection. In negotiations with their employees, certain uniform benefits must be underwritten because not only the employer but the employee representatives of the unions may insist that all employees be treated more or less equally.

Why is it necessary for Blue Shield to be so concerned about national accounts when we have obviously been so successful without providing a national product?

We see before us daily the tremendous number of national groups or national accounts. The nature of bargaining between employers and employees is cutting across state lines and extending clear across the country. For example, the Railroad, Steel and Automobile accounts encompass all of the employees within certain local or specialized unions within the railroad, steel and automobile industries wherever they may be. Previously, we had been able to deal with these groups of employees at a local level. Now some industries are bargaining as a whole and they are demanding uniformity. In such cases the aim of these national organizations is to guarantee to all employees and their dependents identical benefits regardless of what area of the country they may be located.

Acting in behalf of all Blue Shield plans in the country, the national organization—Blue Shield Medical Care Plans, Incorporated—has negotiated with representatives of national accounts and established certain minimum benefits required for enrollment of such accounts by Blue Shield Plans.

The Blue Shield Plan of New Jersey in an effort to maintain national accounts currently enrolled and to be in a position to negotiate the possible enrollment of new national accounts, has had under study for two years certain minimum benefits necessary to enroll national accounts which are unavailable under the Plan's Subscription Contract. With the concurrence of the Department of Banking and Insurance, your Plan has proceeded to develop a series of riders for extended benefits which will be made available to certain group accounts. The riders that have recently been approved by the Department of Banking and Insurance will be offered as supplements to the basic Series 1956 Subscription Contract.

The following are the additional services to be offered under the proposed riders:

1. Extension of medical service to the hospital in-patient.

2. To make all surgical procedures eligible for payment when rendered outside of hospital to the same extent as when rendered in hospital.

3. Radium or radon therapy and radioactive isotope therapy when rendered either to an in-patient or an out-patient in an approved hospital. X-rays and pathology services rendered outside of hospital.

4. Physical therapy rendered outside of hospital.

The Trustees of Medical-Surgical Plan have given long and careful study in their consideration of this matter. They feel that the proposals outlined for national accounts will improve our Contract and provide the minimum essential requirements to maintain our present enrollment among the larger groups of nationwide significance.

1958 BOARD OF TRUSTEES

Charles W. Barkhorn, M.D.	1952
Irving P. Borsher, M.D.	1950
Robert G. Boyd	1957
Charles L. Cunniff, M.D.	1958
Joseph P. Donnelly, M.D.	1953
Joseph I. Echikson, M.D.	1954
Joseph M. Keating, M.D.	1953
Samuel J. Lloyd, M.D.	1958
Arthur W. Linn	1951
Paul Mecray, Jr., M.D.	1953
Duane E. Minard, Jr.	1957
Royal A. Schaaf, M.D.	1942
Rudolph C. Schretzmann, M.D.	1945
James H. Spencer, M.D.	1957
Edward W. Sprague, M.D.	1942
John S. Thompson	1942
Thomas J. White, M.D.	1951
Carl K. Withers	1952

ADVISORS TO THE BOARD OF TRUSTEES

		Term as Board Members
Samuel A. Cosgrove, M.D.	1953	1943-1953
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952
Elton W. Lance, M.D.	1951	1942-1951

Appointment Year Shown After Name.

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

COUNTY	Participating M.D.	Participating D.O.	Participating Total	Non-Participating M.D.	Non-Participating D.O.	Total Eligible Phys.	% P.P. as of 12-29-58	% P.P. as of 12-31-57
Atlantic	168	13	181	22	0	203	89.1	87.9
Bergen	499	37	536	253	3	792	67.6	67.6
Burlington	99	10	109	18	3	130	83.8	81.7
Camden	306	64	370	53	2	425	87.0	85.1
Cape May	45	6	51	7	1	59	86.4	89.2
Cumberland	85	3	88	6	1	95	92.6	91.7
Essex	1262	52	1314	265	10	1589	82.7	83.1
Gloucester	64	9	73	14	5	92	79.3	77.2
Hudson	560	9	569	139	1	709	80.2	78.9
Hunterdon	50	1	51	4	0	55	92.7	86.0
Mercer	321	7	328	56	4	388	84.5	84.8
Middlesex	249	6	255	54	1	310	82.2	82.6
Monmouth	263	17	280	65	3	348	80.4	79.4
Morris	197	9	206	48	3	257	80.1	78.3
Ocean	64	5	69	11	0	80	86.2	83.3
Passaic	411	11	422	128	1	551	76.5	77.4
Salem	45	4	49	3	0	52	94.2	92.4
Somerset	96	1	97	24	1	122	79.5	83.0
Sussex	32	3	35	7	0	42	83.3	76.2
Union	422	23	445	169	4	618	72.0	72.3
Warren	40	2	42	6	0	48	87.5	91.1
Out of State	133	12	145	0	0	145	0	0
Totals	5411	304	5715	1352	43	7110	80.3	80.0

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
*Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
*William J. Carrington, M.D.	1942-1943
Harry N. Comando, M.D.	1942-1958
*Patrick H. Corrigan, M.D.	1952-1958
*William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
*Augustus S. Knight, M.D.	1942-1948
*Thomas K. Lewis, M.D.	1942-1949
*Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951

**Deceased*

PROSPECTS FOR FUTURE EVOLUTION

In November, 1955 the Board of Trustees of The Medical Society of New Jersey, following approval of the proposed Series 1956 Subscription Contract which was to be effective on May 1, 1956, adopted a resolution requesting the Plan to proceed as rapidly as possible for the development of a further new Contract or a revision of Contract. The action of the Board of Trustees was as follows:

"Immediately upon the issuance of its new Series 1956 Subscription Contract, the Plan proceed to prepare a new Subscription Contract to be issued as soon as feasible, implementing the action of the House of Delegates of The Medical Society of New Jersey concerning the inclusion of medical services in the fields of Radiology, Anesthesiology, Laboratory Medicine, Pediatrics, etc., and that it study the problem of increasing the benefits to the Participating Physician."

For more than 30 months, the Plan has been engaged in necessary studies preparatory to fulfilling the request of the Medical Society. We now wish to report to you some of the results of these studies and describe some of the major changes that have been considered in connection with a new Subscription Contract.

The revision of a Subscription Contract, affecting, as it now does, more than 2,000,000 enrolled members is a major undertaking. Each change in the scope of Plan benefits is certain to have profound effects upon the Plan's actuarial basis and financial position. Each change likewise will present us with new problems in the reorientation of subscribers and physicians and in the scope of services to be considered eligible for benefit under the Plan.

In a constant effort to meet the requirements

nd challenges of modern medical practice, ne Plan maintains liaison with representa- ve groups of the profession. To this end, nany conferences have been held, and will ontinue to be held in the future, with repre- entatives of all the general and specialized roups within the profession, not only on hanges in the Schedule of Payments but on ossible alterations in the scope of benefits.

From the mechanical point of view, the is- uance of a new Contract is a massive enter- rise, costing ultimately several hundred thous- nd dollars before the transition from the old o the new is completed—and is subject al- ways, of course, to the approval of the De- partment of Banking and Insurance. For all hese reasons, any general revision of the Subscription Contract, in such an organiza- ion as Medical-Surgical Plan is not an enter- prise to be lightly undertaken nor one that nay be accomplished rapidly.

The following is an outline of changes, of major nature, that are being considered with respect to a new Subscription Contract:

1. *Maternity benefits*—that pre-natal and post- natal care rendered outside of hospital be elimin- ated as an eligible service under a new Subscrip- tion Contract and that Plan payment for obste- trical services shall include only the delivery and postpartum care in hospital.

Adopted (page 474)

2. *Surgical benefits*—that all surgical procedures presently eligible for Plan payment to a bed patient be made eligible for Plan payment when rendered outside of hospital.

3. *Medical benefits*—that the number of eligible days of medical care for hospitalized cases be increased from 21 days per hospital admission to 120 days within a Contract Year. Such extended coverage for medical care obviously represents an important and desirable expansion of scope of Plan benefit. It is a step in the direction of providing more comprehensive coverage against "'catastrophic" illness. It would further provide uniformity with respect to the Hospital Service Plan Contract which provided inclusive coverage for 120 days of hospitalization.

4. *Multiple health and accident insurance coverage and third party liability*—that in cases of third party liability and/or multiple insurance coverage by commercial insurance carriers, a Participating Physician will not be limited to Plan payment regardless of the income of the Subscriber. These changes have been requested by many physicians and represents a radical departure from the existing policy of the Plan. Any change in that direction, however, will be subject to the approval of the State Department of Banking and Insurance.

5. *Income limits*—more stringent controls and greater responsibility upon the Subscriber in the determination as to whether or not "service benefits" are applicable in a given case.

Reference Committee "A"

Mary Bacon, M.D., Chairman

Reference Committee "A" met on Sunday, April 26. Members present were Dr. Mary Bacon, Chairman; Dr. Dorsett L. Spurgeon, Dr. Alan A. J. Stolow, Dr. William E. Dodd, and Dr. John E. Hampton.

1. The report of the *President*, Dr. Kenneth E. Gardner, consisted of a general review of some of the Society's major activities during the past year. Through the entire report Dr. Gardner stressed one basic theme: the desire to improve the quality of medical care to all people and to formulate medical policies and ethical standards worthy of our profession. The President, in his report, reminded the members that liaison committees of the Society work with public health, social, economic, and welfare agencies in handling problems once included by the family physician as part of his individual medical care. This has become necessary because of the pressure made on all physicians by the rapid advances in scientific medicine and because of the increasing complexity of the above-mentioned problems.

Much time and effort have been spent during Dr. Gardner's term of office in cooperative action between the State Society and the State Department of Health in matters such as care of the aged, rehabilitation, poliomyelitis, and the like.

Economics of medical care, prepayment health insurance plans, third party participation in economics, health and welfare funds controlled by industry and labor—the Medical Society's interest in all these for the benefit of physicians and patients has accounted for many hours of dedicated work by many dedicated physician-members.

Dr. Gardner and his associates have worked on the assumption that one of medicine's problems is to retain control of the standards of the quality of medical care, which includes the right of the patient to have free choice of physician and the fee-for-service principle. Retirement plans for the self-employed, controversial social security, legislation related to the practice of medicine, the plight of radiologist and pathologist—all these have represented innumerable conferences and committee meetings of endless hours in which literally hundreds of unselfish physicians participated. Organized medicine is necessary at this stage of civilization and events, and the men who devote time to these essential details do it for the protection and benefit of every individual member of every component county society.

Through Dr. Gardner's leadership and the cooperation of his officers and appointed committees, through the self-sacrificing service of every individual man on the team, the accomplishments of the year now concluding have been satisfying and worthwhile.

Reference Committee "A" commends Dr. Gardner upon his leadership and upon the year's achievements.

Adopted

2. The *Secretary*, Dr. Marcus H. Greifinger, in addition to the mountainous routine of his office, has attended the annual meeting of the American Medical Association in San Francisco and the interim meeting in Minneapolis, as well as all meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

As of December 31, 1958, he reports 6,052 active membership of The Medical Society of New Jersey, of which 5,551 are A.M.A. members. The New Jersey delegation to the American Medical Association, therefore, remains at six. Dr. Greifinger reports that the new *Membership Directory* will be mailed to the membership early in the summer of 1959. Listings were mailed during the year to the members for correction and return.

All this could only be accomplished with the aid of the Executive Offices. The committee wishes to express understanding of all effort involved and to thank a most efficient Secretary to The Medical Society of New Jersey and also to the staff which makes this perfection possible.

Adopted

3. The *Board of Trustees*, Dr. Carl N. Ware, Chairman. Eight meetings of the Board have been held. Dr. Ware credits the Board members and the numerous committees for the most orderly work and efficient conduct of the Society's business.

Regularly the Board of Trustees has dealt with correspondence and resolutions from members, component societies and outside organizations; appointment of representatives to local, state, and national meetings; nominations to the State Board of Medical Examiners; action on the reports or recommendations of the standing and special committees, including the Welfare Committee, its sub and special committees; cooperation with the departments of the state government and with the allied professions—dentistry, pharmacy, nursing, legal, and hospital administration.

The following additional matters have been the concern of the Board of Trustees, but are to be taken up individually by other appropriate reference committees: Medical Student Loan Fund (B), Blue Cross Interplan Service Bank (C), Health Care of the Aged (C), Medical Service Administration (C), Medical-Surgical Plan (C), Medicare

Program (C), Liability Countersuit (D), Examination of Hospital Records (E), Intravenous Medication by Nurses (E), Pre-School Inoculations and Vaccinations (E), Social Security for Physicians (E), Technical Services by Non-Professional Personnel (E).

This reference committee noted in the supplemental report of the Board of Trustees the recommendation of the Special Committee on Medical-Legal Testimony that The Medical Society of New Jersey adopted the "National Interprofessional Code for Physicians and Attorneys" and commentaries thereon as they relate to The Medical Society of New Jersey and as prepared by the Society's legal counsel. The Board of Trustees approved the code and commentaries and directed that the county societies be encouraged to achieve the adoption at county level.

The resolution on "Impartial Medical Witnesses," prepared by the Special Committee on Medical-Legal Testimony and adopted by the Board of Trustees, is recommended for favorable action by the House of Delegates.

Adopted

Reference Committee "A" recognizes the amount of work and altruistic interest involved in the conduct of this amount of work for the Society and sincerely wishes to thank for The Medical Society of New Jersey, Dr. Carl N. Ware, Chairman, and the Board members; Drs. Wegryn, Allman, Mulligan, Sharp, Kaufman, Hamilton, Donnelly, Sica, Blaisdell, Jehl, Fritts, Gardner, Bowers, McCall, Buchanan, Schretzmann, and Greifinger.

Adopted

4. The *Judicial Council*, Dr. Daniel F. Featherston, Chairman. During the year the Judicial Council reports three appeal hearings granted, four formal opinions rendered, seventy-three complaints reported as disposed of by county judicial committees, and fourteen complaints still pending. Council meetings regularly consumed four or five hours each month.

We wholeheartedly commend Dr. Featherston and his Council members for the approbation of the House.

Adopted

5. *Reference Committee "A"* reviewed the resolution "Voluntary Association Between Physicians and Optometrists" presented by Essex County.

The Chairman of the Judicial Council, Dr. Featherston, appeared before the reference committee and made the following statement in conjunction with this resolution:

> By the adoption in 1955 of Resolution No. 77, this tenet was incorporated as of that time into the Code of Ethics of the American Medical Association.
>
> Inasmuch as Chapter I, Section 4, of the By-laws of The Medical Society of New Jersey declares: "The 'Principles of Medical Ethics' adopted by the American Medical Association shall govern the conduct of the members in all categories of The Medical Society of New Jersey in their relations to each other and to the public," this Society's endorsement of the ethical tenet involved was automatic and immediate. No further action is in order.

In this conclusion the reference committee unanimously concurs. Inasmuch as the purpose of this resolution has already been automatically realized, Reference Committee "A" recommends the rejection of the resolution.

Adopted

6. Richard I. Nevin, *Executive Officer*. This report necessarily embodies a summary of the activities and accomplishments of the administrative year, and it is inescapable that he cite data of information separately supplied in the reports of other officers and committee chairmen.

We quote directly from Mr. Nevin's annual report. It gives, in the most effective possible way, the "feel" of just what is happening to organized medicine.

> The year has been the most active and demanding that I have known since taking office in 1951. Medical Society business seems progressively to be involved in a spiral of expansion, intensification, and acceleration, not only in New Jersey but everywhere in the nation. Our concerns—both in the internal workings and relations of organized medicine and in external relations with other agencies of all kinds—seem to multiply with every passing year, and the tension and tempo of our duties proportionately to increase. We hope that our efforts are carrying us and our purposes forward, but as Lewis Carroll has Alice say somewhere in his narrative of her adventures, "You have to run very fast to stay in the same place." We are giving our all to the effort of running and breathlessly praying for a strengthening second wind.

Mr. Nevin, in the course of the concluding administrative year, in addition to his regular official duties, has participated in about 180 meetings, made eight trips out of the state on business of the Society, and filled fifteen speaking engagements.

Mr. Nevin states that the President and the officers of the Society and he himself have met each new challenge head-on and vigorously dealt with it in the spirit of "all for one and one for all."

Accolades are in order, and the committee recommends that they be given not only to Mr. Nevin, but to Mr. Nevin together with all those who have this year actively served medicine and the people of New Jersey through service to The Medical Society of New Jersey.

Adopted

Report as a whole adopted

Reference Committee "B"

Gerard R. Gessner, M.D., Chairman

Reference Committee "B" met on April 26, 1959. Present were: Gerard R. Gessner, M.D., Chairman, Joseph E. Mott, M.D., Edward G. Bourns, M.D., Sherman Garrison, Jr., M.D., and Morton F. Trippe, M.D.

1. The committee reviewed the report of the *Treasurer* of this Society, and unanimously approved the interim report covering accounts from June 1, 1958 to March 31, 1959. A question arose concerning the large amount in the checking account. This is so only because of the recent receipt of assessments, and the liabilities currently payable makes this amount necessary. The committee commends Dr. Schretzmann, the Treasurer, and the Finance and Budget Committee for their judicious use of short term interest accruing investments.

Adopted

2. Your committee considered the *Medical Student Loan Fund* report, and concurs with the feeling that the Fund should be self-perpetuating, and recommends approval of the recommendations referred by the Board of Trustees to the Finance and Budget Committee, as follows:

1. That an appropriation of $5,000 each year be included in the budget to maintain the Medical Student Loan Fund.
2. That for this year (1958-59) the interest income from investments be paid into the Medical Student Loan Fund.

Adopted

3. Your reference committee unanimously approved the report of the *Finance and Budget Committee* with commendation not only for its chairman, Dr. Allman, but for all the members of the committee for their attention to a very onerous task. Your reference committee unanimously concurred in the recommendations submitted by the Finance and Budget Committee, viz.:

1. Budget for 1959-1960
   That the budget for 1959-1960 be adopted in the sum of $183,813.00.

Adopted

2. 1960 Per Capita Assessment
   That the 1960 assessment be adopted at $35 per capita with no provisions for contribution to A.M.E.F.

Adopted

3. (a) That the per capita level of contribution to A.M.E.F. for 1960 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Your reference committee recommends that for 1960 a per capita contribution of $5.00 is not unreasonable, and so recommends to the House.

Adopted

(b) That the 1959 contribution to A.M.E.F. be in the amount of $10,000, payable from the reserve account set aside for this purpose from the 1959 assessments.

Adopted

4. Your reference committee reviewed the report of the *Publication Committee* as submitted by its chairman, Dr. Fred B. Rogers, and wishes at this time to commend all those connected with the publication of THE JOURNAL, and especially Dr. Henry A. Davidson, Editor. The Publication Committee should certainly be given a vote of thanks in that for the fourth consecutive year the Publication Committee makes no request for funds for publication costs of THE JOURNAL. They expect to operate on their excess of advertising income over publication costs.

Adopted

5. Your reference committee reviewed the report of the Special Committee on the *Medical Student Loan Fund,* under the chairmanship of Dr. F. Clyde Bowers. Your reference committee commends Dr. Bowers and his entire committee for the efficient manner in which they have handled this worthy project. We further recommend that all the members of the Society be constantly thinking of this Fund as a philanthropy to which they judiciously contribute.

Adopted

6. After listening to considerable discussion concerning the report of the *Finance and Budget Committee,* your reference committee decided it could *not* favor the resolution from Medical Service Administration soliciting a contribution of $5,000 for M.S.A. in 1960.

The committee did approve the Supplemental Report of the Board of Trustees, which concludes that further subsidization of M.S.A. by The Medical Society of New Jersey should not be necessary and is not justified.

It was the unanimous conviction of your committee that the administrative expenses of Medical Service Administration should be met by those agencies immediately receiving its services. At no time in the past years has Medical Service Administration been denied funds on request to the

Board of Trustees of this Society. Your committee recommends that should urgent financial need arise in the future, specific requests should be submitted to the Board of Trustees.

Your reference committee wishes to commend Medical Service Administration for the accomplishment of the services for which it was originally intended, and urges that the Medical Service Administration continue in being.

Adopted, Dr. Schaaf dissenting on behalf of Medical Service Administration.

Report as a whole adopted

Reference Committee "C"

Joseph M. Gannon, M.D., Chairman

Reference Committee "C" met April 26, 1959, with all members present, and with an audience of some fifty or more interested delegates and members in attendance.

The following matters were considered:

1. The report from the Board of Trustees, *Blue Cross Inter-Plan Service Bank* was read and approved as read.

Adopted

2. The report on *Health Care of the Aged* was discussed at great length and after consideration by your committee, was not approved. In failing to approve this report, your committee was motivated by the following:

(A) Since the time of the writing of this report the actuaries of the Medical-Surgical Plan find that to pay physicians' fees which would be about 30 per cent less than those now allowed, the premium for this group would have to be not reduced, but actually increased ($3.12 per year for a couple).

(B) The precedent of setting reduced fees for physicians in any contract is hazardous because of the likelihood that ultimately the contracts would embrace persons of younger age and greater resources.

(C) The terms "reduced income and modest resources" have not been clearly defined in the report.

(D) The economic burden of carrying this segment of society would not rest equally on the shoulders of all types of medical practitioners.

(E) We agree with the statement of the Board of Trustees that failure to supply hospital services at reduced costs to the needy will render fruitless any and all other efforts to supply their (medical) needs.

We recommend that further study of this problem by the Medical-Surgical Plan, the New Jersey Hospital Association, and The Medical Society of New Jersey be undertaken with the objective of providing suitable prepayment hospitalization for this group, and with the objective of considering the possibility of increasing all present existing premiums so that medical coverage for this group could be provided at a nominal cost to the subscribers.

We urge that all physicians continue to care for the members of this group as they have done heretofore, either at a reduced rate or gratis, as the situation demands.

We recommend that our delegates to the American Medical Association be instructed to act in conformity with the action of the House of Delegates in this matter.

The report on *Health Care of the Aged* was discussed at great length. The House finally voted to:

Refer this report back to the Board of Trustees with power to act.

3. Report of the Trustees on *nominations for the Board of Governors* of Medical Service Administration (1959) was read and approved.

Adopted

4. The report of the Board of Trustees on new *nominations to the Board of Trustees of the Medical-Surgical Plan* for 1958-1959, as well as nominations for membership on the Board of Trustees of Medical-Surgical Plan for 1959-1960, was read and approved as read.

Adopted

5. The report of the Board of Trustees on the *Medicare Program* was read and approved as read.

Adopted

6. The supplemental report of the Trustees concerning *payment to chiropodists by the Medical-Surgical Plan* was read. While Reference Committee "C" approved the report of the Trustees regarding payments to chiropodists, it wishes strongly to indicate its dissatisfaction with the 1953 supplement to the Enabling Act which forces Medical-Surgical Plan to make payment to others than persons holding a full license to practice medicine in New Jersey. It recommends that the matter be referred back to a proper committee for further consideration. Attention is invited to the fact that at the 1958 meeting of the House of Delegates this matter was considered and this House approved the following action:

"The Board of Trustees urgently requests the Trustees of Medical-Surgical Plan of New Jersey to continue the limitation of its payments of eligible benefits to persons holding full licenses to practice medicine in the State of New Jersey in the present contract and in all contracts to be issued in the future."

Adopted

7. The supplemental report of the Board of Trustees regarding *contract inequities* relating to multiple surgical type coverage, third party liability, and income classification was approved as read.

Adopted

8. The report from the Board of Governors of the *Medical Service Administration* of New Jersey was approved as read.

Adopted

9. The report of the Trustees of *Medical-Surgical Plan* was read in its entirety and approved as read.

Adopted

10. The resolution from the Mercer County Medical Society regarding *paid up policies in Blue Cross and Blue Shield* was approved as read. This resolution is limited to further study, and does not make any definite commitments in the matter.

Adopted

11. A resolution from the Bergen County Medical Society concerning *health care of the aged* was read and was not approved. The phrase "and fees to physicians proportionately reduced" subjects this resolution to the criticisms that we applied to a similar report from the Board of Trustees on health care of the aged earlier today.

We, of course, approve of the principle of formulating a Blue Shield plan for senior citizens with limited means.

Adopted

12. A resolution concerning *x-ray diagnostic services* from William L. Palazzo, M.D., a delegate from Bergen County, was read. To remove ambiguity, your reference committee moves that this resolution be restated from its present:

"Resolved, That the Medical-Surgical Plan of New Jersey use discretion in formulating its plan of payment for x-ray diagnostic services. This could be done simply by excluding payment to physicians for self-referred x-ray examinations."

to read:

"Resolved That the Medical-Surgical Plan of New Jersey in formulating its plan of payment for x-ray diagnostic services exclude payment to physicians for self-referred x-ray examinations."

Your committee does *not approve this resolution*. We feel that most self-referred x-ray examinations are *bona fide* and justified, and that payment for them is proper.

Dr. Palazzo, in accepting the foregoing revision, wished to further add the phrase "or limit payment to physicians who are qualified to use x-rays within the confines of their specialties."

Your committee felt that this addition would materially alter the original subject and intent of the resolution which had been referred to it, and therefore would not accept this further amendment.

Adopted

The chairman thanks all members of the committee and those interested physicians for their attendance.

Report as a whole as amended—Adopted

Reference Committee "D"

Winton H. Johnson, M.D., Chairman

Reference Committee "D" met at 11:00 a.m., Sunday, April 26, 1959, with all members present. The committee is grateful to the many doctors who gave their opinions in the matters assigned to this committee. Consideration was given to these opinions in the recommendations of Reference Committee "D", which follow:

1. *Board of Trustees*

A. The committee approves the action taken by the Trustees referring to the subject of *Liability Countersuit.*

Adopted

B. *Accreditation of Hospitals and Intern and Resident Training Programs*—A lively discussion by the audience followed. Although the committee is cognizant of the many problems involved

n this resolution and its many "whereases," the ommittee approves the resolution in the sense hat the resolution requests a review of the pro- edures of accreditation of hospitals and intern nd residency training programs and further that f improved recommendations be formed that they hall be implemented.

Disapproved

C. *Foreign Medical Schools*—The committee approved the resolution with the recommendation that the role of the present Educational Council for Foreign Medical Graduates in supplying interns and residents for the many vacancies in our hospitals be given due consideration.

Dr. Butler, originator of the resolution, assured the reference committee that this will be done.

Adopted

2. *Medical Defense and Insurance Committee—Professional Liability*

A. The reference committee is grateful to Dr. Hurff and his committee for the tremendous work they have done on behalf of the doctors in this Society and the detailed annual report and its supplement.

The reference committee approves this portion of the report.

Adopted

B. The additional supplementary report of the Medical Defense and Insurance Committee and its recommendation were disapproved for two reasons:

1. Members of the Board of Trustees present at the reference committee meeting assured the reference committee that the problem will be under study on April 28 at the Annual Meeting.

2. The committee could not approve the coercive tenor of the recommendation by the Medical Defense and Insurance Committee as a way of solving the problem of liability coverage.

Adopted

3. Report of *Medical Education Committee* was approved.

Adopted

4. Report of *Physicians Placement Service* was approved.

Adopted

5. Report of *Traffic Safety Committee* was approved.

Adopted

6. Report of *Retirement Plan for Physicians* was approved.

Adopted

7. Report of *Civil Defense-Disaster Control Committee* shows some serious defects in this program and the members are to be congratulated in their efforts to cope with the problem.

The report of the Civil Defense-Disaster Control Committee was approved.

Adopted

Report as a whole as amended—Adopted

Reference Committee "E"

John J. Torppey, M.D., Chairman

The reference committee met on April 26. All members were present.

A. *Items from the report of the Board of Trustees*:

1. *Examination of Hospital Records*—This committee notes that proper enforcement of the existing law would protect hospital records from a review by unauthorized persons. The Board of Trustees has transmitted this information to the hospitals through the New Jersey Hospital Association.

Adopted

2. *Intravenous Medication by Nurses*—Approved by the reference committee.

Adopted

3. *Pre-School Inoculations and Vaccinations*—Approved by the reference committee.

Adopted

4. *Social Security for Physicians*—This committee is cognizant of the information contained in this portion of the Board report. It is factual information which will be used in deliberations

on this same subject, later in this reference committee report.

Adopted

5. *Technical Services by Non-Professional Personnel*—The committee views with concern the implications of the proposed amendment to the Medical Practice Act which would authorize medical and other technicians to act on the specific order of a physician. Such medical technicians, when not engaged by the physician to render services to him, render services to the public as independent operators. The physician can then exercise only limited supervision. It is questionable whether all classes of technicians should be permitted to function in this fashion. It is recommended that this matter be referred back to the Board of Trustees for further study.

Adopted

6. *Blood Bank Commission*—Approved by the reference committee.

Adopted

7. *Nursing Homes for the Aged and the Chronically Ill*—The reference committee agrees with the special committee that this resolution is commendable but impracticable. We recommend that this resolution be *not* adopted.

Adopted

8. *Tuberculosis Screening of School Children*—The committee approved the recommendations of the Board of Trustees contained in this report.

Adopted

B. *Committee reports*:

9. *Medical Practice Committee*—Your reference committee endorses the recommendations contained in this report. It is of the utmost importance that we continue to be alert to infringement on the practice of medicine.

Adopted

10. *Public Health Committee*—The committee recognizes the tremendous responsibilities involved and the effort expended by this committee, and recommends the acceptance of this report.

Adopted

11. *Public Relations Committee*—The committee reviewed this report with pride, and commends most highly the members of the committee for their continued good work.

Adopted

12. *Cancer Control Committee*—This committee approves the report and recommendations of the Cancer Control Committee.

Adopted

13. *Cancer Control Committee Supplemental Report*—This committee recognizes the dangers of ionizing radiation and further recognizes the value of this supplemental report on radiologic hazards. We recommend the acceptance of this report and further recommend that this report be made available to all practicing physicians in New Jersey.

Adopted

14. The reference committee approved, and recommends acceptance of, the following reports as submitted:

Welfare Committee
Maternal and Infant Welfare Committee
Legislative Committee (annual and supplemental)
Industrial Health Committee
Workmen's Compensation Committee
Child Health Committee
Chronically Ill and Aging Committee
Conservation of Hearing and Speech Committee
Conservation of Vision Committee
Mental Health Committee
Rehabilitation Committee

Adopted

C. *Resolutions*:

15. *Ocean County Resolution on Hypnosis*—We recommend that this resolution be adopted.

Adopted

16. *Social Security Resolutions from Mercer, Bergen and Essex Counties*—After spirited discussion there was no doubt that the majority opinion of those appearing before this committee, and the reports of the polls conducted, were in favor of the inclusion of physicians under Social Security. In view of these facts, this committee recommends the adoption of the Mercer, Bergen and Essex resolutions.

Adopted

17. *Essex County Resolution on Optometrists—Contact Lenses and Drugs*—This committee recommends the adoption of this resolution.

Adopted

18. *Cumberland County Resolution on Optometrists and Drugs*—We recommend the adoption of this resolution.

Adopted

19. *Resolution on Rehabilitation Services Directory from Burlington, Mercer and Somerset Counties*—We recommend the adoption of this resolution.

Adopted

Report as a whole adopted

Reference Committee on Miscellaneous Business

Albert Abraham, M.D., Chairman

The Reference Committee on Miscellaneous Business met on April 26, 1959. Present were: Albert Abraham, M.D., Chairman, Andrew C. Ruoff, III, M.D., Martin E. Tolomeo, M.D., Raymond A. Taylor, M.D., and Herschel Pettit, M.D.

1. The reference committee considered the report of the *Committee on Scientific Exhibits* and recommends adoption of this report *in toto*.

Adopted

2. The reference committee considered the report of the *Committee on Scientific Program* and recommends the adoption of this report *verbatim*.

Adopted

3. The reference committee considered the report of the *Advisory Committee to the Woman's Auxiliary* and recommends the adoption of this report as submitted.

Adopted

4. The reference committee carefully studied the report of the *Committee on Annual Meeting* and recommends the adoption of this report in which it is recommended that the 197th Annual Meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City, beginning Saturday, May 11, through Wednesday, May 15, 1963.

After discussion, the reference committee recommends that the Annual Meeting Committee study the feasibility of opening the technical exhibits to the Delegates on Sunday afternoon, since many of the Delegates leave on Monday after the House has adjourned.

Adopted

Report as a whole adopted

Reference Committee on Resolutions and Memorials

John L. Olpp, M.D., Chairman

The Reference Committee on Resolutions and Memorials met on April 26, 1959. Present were: John L. Olpp, M.D., Chairman, Ernest F. Purcell, M.D., E. Vernon Davis, M.D., Henry O. von Deilen, M.D., and Louis K. Collins, M.D.

1. No names were submitted for Honorary Membership in The Medical Society of New Jersey by the *Committee on Honorary Membership*.

Adopted

2. The following nominations for *Emeritus Membership* were received and approved:

Bergen County

Clarence A. Connor, Fort Lee; age 73
Charles B. Warren, Ogdensburg, N. Y. (formerly Bergenfield); age 75
William C. Williams, Rutherford; age 75

Essex County

Julius Bernstein, North Miami, Fla. (formerly Newark); age 63
LeRoy Colsh, Bay Head; age 70
Haynes H. Fellows, Maplewood; age 68
E. Zeh Hawkes, Newark; age 94
George J. Holmes, Summit; age 82

Union County

James G. Boyes, South Plainfield; age 65
E. Hugh Doggett, Plainfield; age 68

Adopted

Report as a whole adopted

Constitution and Bylaws

Lorrimer Armstrong, M.D., Chairman

The Reference Committee on Constitution and Bylaws met at 11:00 a.m., April 26, 1959, for the consideration of the revision of the Constitution and Bylaws. The following committee members were present: Lorrimer Armstrong, M.D., Chairman, John J. Bedrick, M.D., Raymond J. Gadek, M.D., James R. Eynon, M.D., and G. Ruffin Stamps, M.D.

1. Considered first were the proposed *Amendments to the Constitution*—Articles IV, IX, and XII. The reference committee approved the proposed amendments as submitted. (See page 430)

The House of Delegates voted separately and favorably on each section. The proposed amendments to the Constitution were accepted for final consideration in 1960.

2. The proposed *Amendments to the Bylaws*—Chapters II, III, V, and VI—and the proposed *Revision of the last half of the Bylaws*—Chapter XI through XII—were approved by the reference committee as submitted (see page 431), except for the changes in wording indicated below. Each chapter and section was separately considered by the House of Delegates.

Changes proposed by the reference committee in Chapter XI, Section 2 of the Bylaws.

In the listing below, underlining indicates words inserted; parentheses indicate words deleted by the reference committee. The House adopted these recommendations of the reference committee.

(b) To be eligible for membership, the applicant must:

(1) be a citizen of the United States;

(2) hold a degree (of Doctor of) in Medicine acceptable to this Society obtained from a medical school approved by this Society at the time of his graduation;

(3) be fully licensed (as a physician and surgeon) to practice medicine and surgery by the New Jersey State Board of Medical Examiners;

The House of Delegates voted favorably on each recommendation of the reference committee with respect to Bylaws. Amendments proposed for Chapters II, III, V and VI of the Bylaws were adopted. Proposed revisions of Chapters IX through XII were adopted as amended.

Report as a whole adopted

Special Action by Delegates

1958 TRANSACTIONS

At its first session on Saturday afternoon, April 25, 1959, the House of Delegates approved:

The Transactions of the 1958 House of Delegates as published in the July, 1958, JOURNAL and distributed to the membership.

REPORT OF THE NOMINATING COMMITTEE AND ELECTION

(April 26, 1959)

Office	*Term*	*From*		*To*		*Nominee*
President-Elect	1 year	April	1959	May	1960	Jesse McCall, Sussex County
1st Vice-President	1 year	April	1959	May	1960	Ralph M. L. Buchanan, Warren County
2nd Vice-President	1 year	April	1959	May	1960	Louis S. Wegryn, Union County
Secretary	1 year	April	1959	May	1960	Marcus H. Greifinger, Essex County
Treasurer	1 year	April	1959	May	1960	Rudolph C. Schretzmann, Bergen County
Trustees:						
1st District	3 years	April	1959	May	1962	Nicholas A. Bertha, Morris County
3rd District	3 years	April	1959	May	1962	Lloyd A. Hamilton, Hunterdon County
5th District	3 years	April	1959	May	1962	David B. Allman, Atlantic County
11th Trustee	3 years	April	1959	May	1962	Luke A. Mulligan, Bergen County
Councilors:						
2nd District	3 years	April	1959	May	1962	John L. Olpp, Bergen County
5th District	3 years	April	1959	May	1962	Isaac N. Patterson, Gloucester County
A.M.A. Delegates	2 years	Jan.	1960	Dec.	1961	William F. Costello, Morris County
	2 years	Jan.	1960	Dec.	1961	Aldrich C. Crowe, Cape May County
A.M.A. Alternates	2 years	Jan.	1960	Dec.	1961	Joseph P. Donnelly, Hudson County
	2 years	Jan.	1960	Dec.	1961	Elton W. Lance, Union County
Delegates and Alternates to Other States:						
New York						
Delegate	1 year	1960	New York Convention			William F. Costello, Morris County
Alternate	1 year	1960	New York Convention			Levi M. Walker, Atlantic County
Connecticut						
Delegate	1 year	1960	Connecticut Convention			Lloyd A. Hamilton, Hunterdon County
Alternate	1 year	1960	Connecticut Convention			S. Eugene Dalton, Atlantic County
Standing Committee:						
Publication	3 years	April	1959	May	1962	C. Spencer Davison, Salem County

Upon motion duly made, seconded, and carried, all nominees were elected in the designated offices and for the terms indicated.

Address of the President

Kenneth E. Gardner, M.D., Bloomfield

Members of the House of Delegates: The President is required by the By-Laws to make an address at the annual meeting. I can assure you that it will be brief, but I cannot permit this occasion to pass without expressing to you my appreciation for the privileges and honor of serving The Medical Society of New Jersey during the past year as your President. By the very nature of this office it is a distinction which can only be conferred upon a few physicians and one which any member of our Society would be proud to fill. It has been most gratifying to me to have had the close cooperation and association with so many members of our Society.

As a supplement to the President's Annual Report which you have all received, I would like to present to you one of the most important issues with which the medical profession is confronted. It will be a major problem for discussion and decision by the House of Delegates of the American Medical Association when they meet here in Atlantic City in June.

The issue is whether the medical profession will continue to maintain that the highest quality of medical care is given by the well established and proved two-party patient-physician relationship which includes free choice of physician and fee-for-service, or whether the medical profession will accept and endorse third-party intervention into this patient-physician relationship by the establishment of closed panel medicine with limited or no free choice of physician, fixed fees or salaries for physicians, and participation in, if not eventual control of, the quality and policies of medical care by non-professional individuals, groups or government.

This is an issue which will greatly affect the future practice of medicine. Change is inevitable but not all change is progress. It is essential, therefore, to evaluate any change in the two-party patient-physician relationship on the basis of its effect on the quality of medical care.

The cost of medical care has become an important factor in our economic thinking. In the two-party patient-physician relationship service is the dominant factor. The cost for service is arranged between the patient and the physician with the patient choosing his own physician and the financial arrangements decided between them.

With third-party intervention cost is the dominant factor. The cost of medical care is arranged by the third party for the patient and the physician. The patient may or may not still have free choice of physician.

Third-party intervention can eventually control the practice of medicine and destroy the two-party patient-physician relationship by establishing panel medicine, limiting or denying free choice of physician, fixing all fees and salaries and by making medical policy to decide both the quality and quantity of medical care. Closed panel medicine leads to regimentation of both patient and physician.

There are some physicians who feel that the long established two party patient-physician relationship with free choice of physician and fee-for-service is no longer applicable and that regimentation of the patient and the physician by closed panel medicine is better suited to the modern economic trend. Personally, I cannot accept this philosophy and I hope that all of you agree with me. Whatever your opinion and decision will be, let us always consider first, however, what is best for our patients and which system will provide the highest quality of medical care.

I should like to sincerely thank all the members of The Medical Society of New Jersey for the honor of representing you during the past year. I hope that I have fulfilled at least in part your expectations. Whatever has been accomplished is never done by the President alone for without the loyal support of the officers, the trustees, the delegates, the committee chairmen, the Woman's Auxiliary and the entire membership little or nothing could be accomplished. I should like to thank the Executive Officer and the Administrative Secretary and their staffs for their willingness and helpfulness at all times.

This has been a most rewarding experience for me and I am sincerely grateful for the wonderful cooperation I have received. It is my wish that The Medical Society of New Jersey will continue to enjoy the high esteem in which it is held throughout the State, that it will continue unswervingly to work for the right of every individual to have free choice of physician, and that it will continue to provide the highest quality of medical care for all of our people. Thank you.



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children. Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

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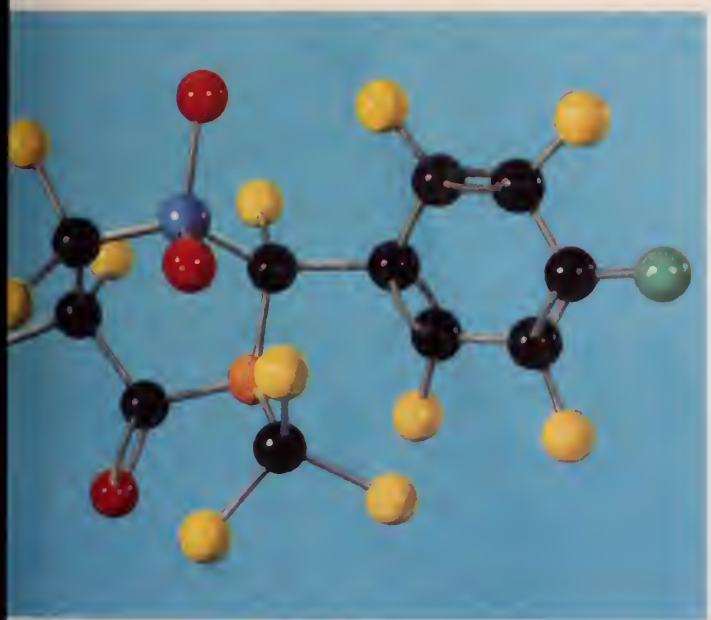
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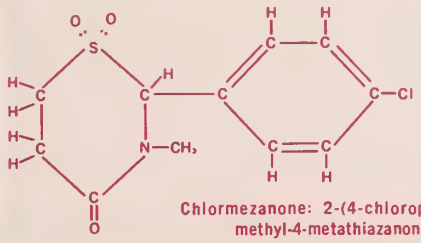
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Trancopal, a major development of Winthrop research, is a new, orally administered non-hypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

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Clinical studies of over 4400 patient
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Trancopal remarkably effective in
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By relieving muscle spasm and pain, Trancopal permits early and active exercise and physical therapy to accomplish maximal benefits for rapid recovery.

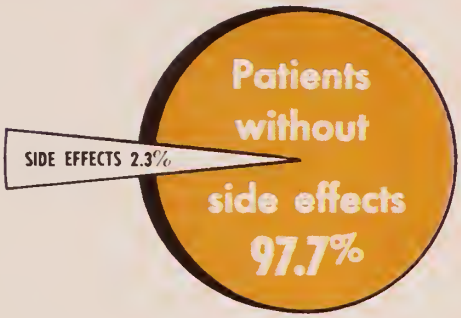
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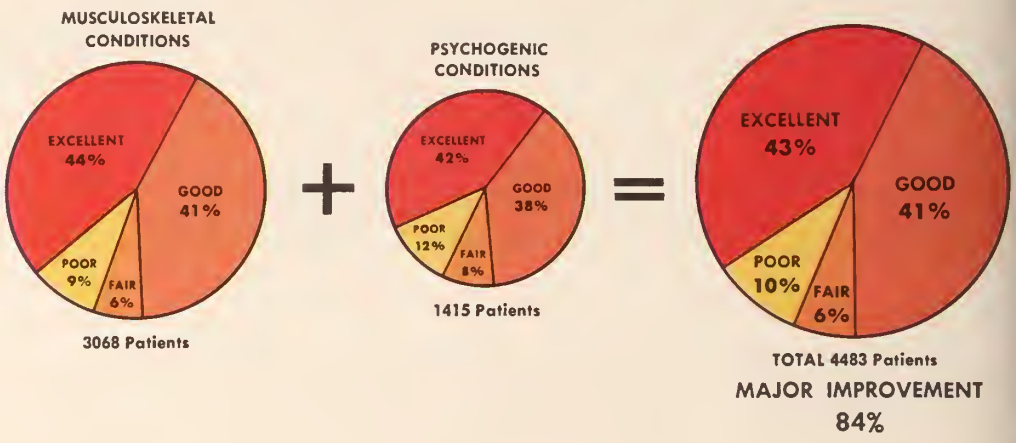
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Dosage: 100 to 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Thoroughly evaluated clinically . . .

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INDICATIONS

Musculoskeletal

- Low back pain (lumbago)
- Neck pain (torticollis, etc.)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disk syndrome
- Fibrositis
- Ankle sprain, tennis elbow, etc.
- Myositis
- Postoperative muscle spasm

Psychogenic

- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Angina pectoris
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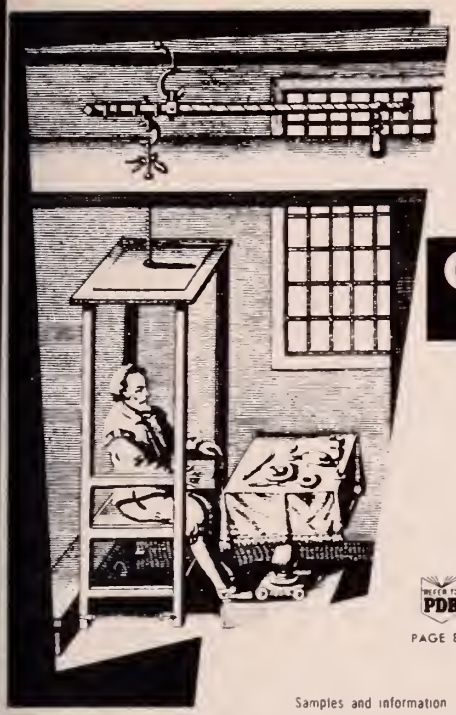
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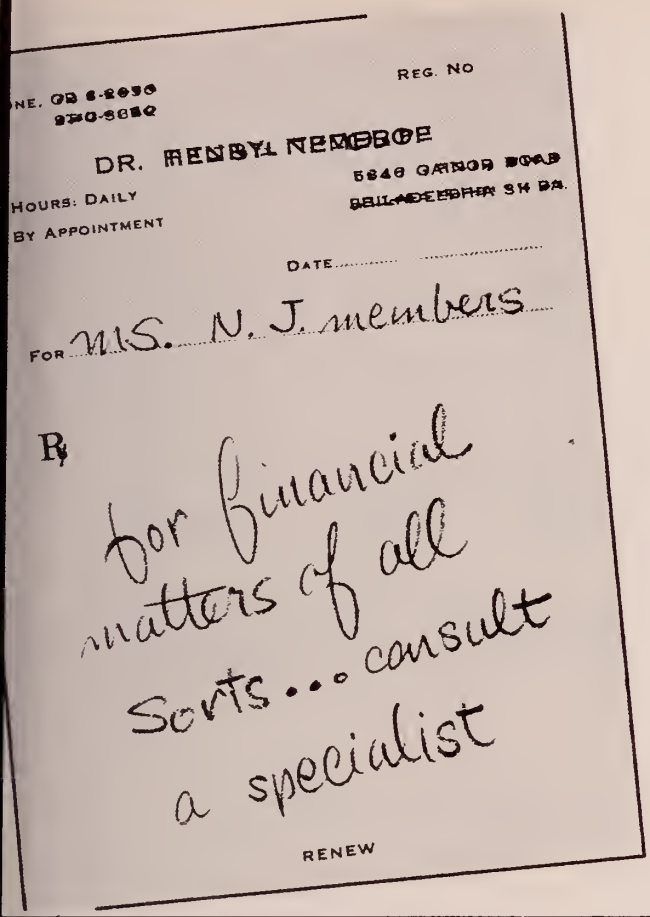
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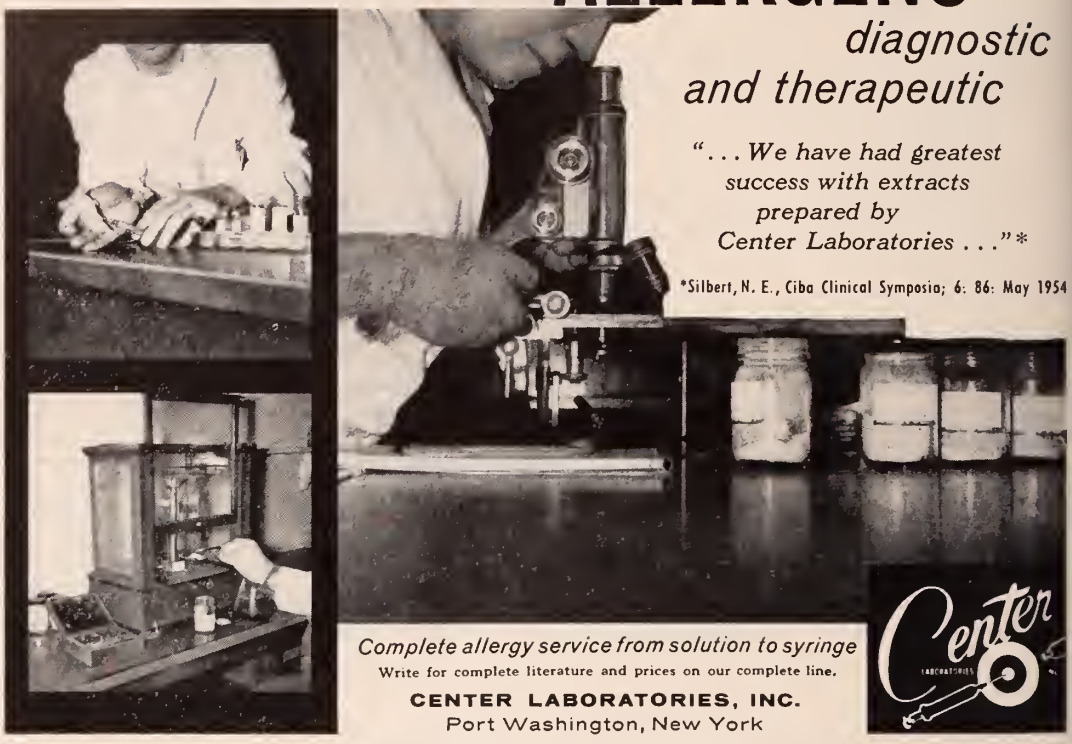
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CONTENTS—Pages 481 to 528

ITORIALS— Page

Blood Samples and Incompetent Patients ... 481

Discovery of the Aged ... 482

Funeral Director: Friend in Need ... 483

RIGINAL ARTICLES—

Lead or Be Led—F. Clyde Bowers, M.D., Mendham, N. J. ... 484

Staphylococcus Pneumonia—Thomas M. Kain, Jr., M.D., Bascom S. Waugh, M.D. and George T. Hare, M.D., Camden, N. J. ... 487

Use and Abuse of Medical Hypnosis—Jacob H. Conn, M.D., Pikesville, Md. ... 491

The New Look in School Health Programs—Phoebe Hudson, M.D. and Irving M. Levitas, M.D., Westwood, N. J. ... 496

Differential Diagnosis with Serum Phosphatase—A. L. Cantelmo, M.D., East Orange, N. J. ... 501

Cerumenolysis with a New Agent—John P. Dirr, M.D., *et al.*, Riverton, N. J. ... 504

Page

Galvanic Skin Response Audiometry in Litigated Cases—Henry Z. Goldstein, M.D. and Herbert E. Rickenberg, M.A., Newark, N. J. ... 507

Omental Infarction—John A. Sakson, M.D., Camden, N. J. ... 511

Pelvic Abscess Following Appendicitis—Celestino Clemente, M.D., Glen Ridge, N. J. ... 513

STATE ACTIVITIES—

Trustees' Meeting ... 516

Roster of Special Committees ... 517

Our Life Insurance Quota ... 521

ANNOUNCEMENTS ... 522

COUNTY SOCIETY REPORTS ... 524

MARGINALIA OF MEDICINE ... 525

OBITUARIES ... 526

BOOK REVIEWS ... 526

Roster of Officers and Committee Chairmen, Advertising Page 3A

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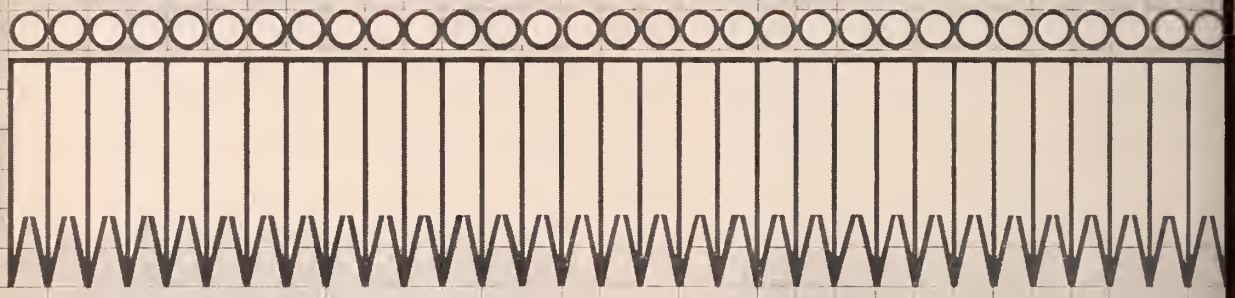
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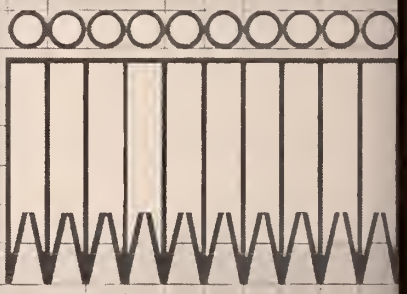
Decadron®

DEXAMETHASONE

treats more patients more effectively...



Of 45 arthritic patients who were refractory to other corticosteroids*





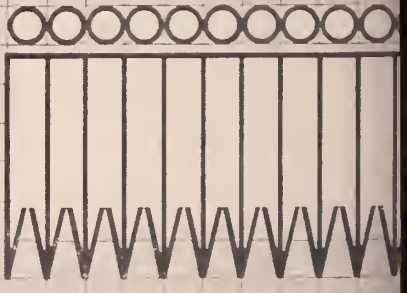
22 were successfully treated with Decadron[1,2]

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

DECADRON is a trademark of Merck & Co., Inc.

Additional information on DECADRON is available to physicians on request.



MSD Merck Sharp & Dohme

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

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NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

IDENTAL BODILY URY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

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(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

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0.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
0.00	7,500	43.60	50.35	63.85
0.00	10,000	57.70	66.70	84.70
0.00	15,000	85.90	99.40	126.40
0.00	20,000	114.10	132.10	168.10
0.00	20,000	141.30	163.80	208.80
0.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

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With the intensive publicity being given to porous cigarette paper in recent weeks, Kent believes that doctors would be interested in knowing the scientific facts about the paper used in today's Kent cigarettes.

Kent's exclusive super-porous Micropore paper lets cool air in, lets heat escape through microscopic pores in the paper. The increased oxygen in the tobacco cylinder brings about more complete combustion of the tobaccos. As a result, Kent smokers have been getting a cooler, cleaner, fresher taste in smoking.

When the advantages of Kent's Micropore paper are coupled to Kent's other superiorities, it is easy to understand why more people, during the past year, changed to Kent than to any other cigarette in America.

Kent smokers also enjoy a free and easy draw, which brings through the rich taste of Kent's costly blend of 100% natural tobaccos. In addition, Kent's exclusive Micronite Filter has made a significant contribution in the area of filtration: Kent has reduced tars and nicotine to the lowest level among all leading brands.



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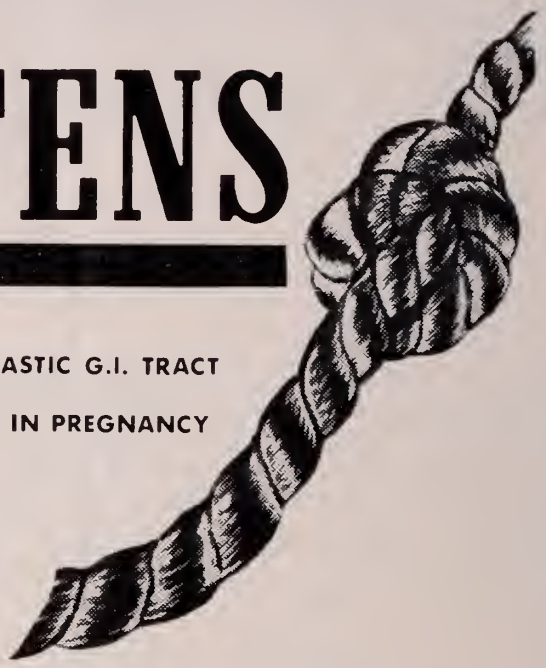
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Each Tablet Contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

DOSAGE: 1 tablet morning and night

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50 gram

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smaller, portable container
topical "Meti" steroid relief in a pocket-size dispenser that patients can carry with them

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supplies sufficient medication for average short-term therapy at lower initial cost

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for poison ivy dermatitis, summer exacerbations of skin allergies

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METI-DERM Aerosol—
50 Gm. container—16.6 mg. prednisolone.
150 Gm. container—50 mg. prednisolone.

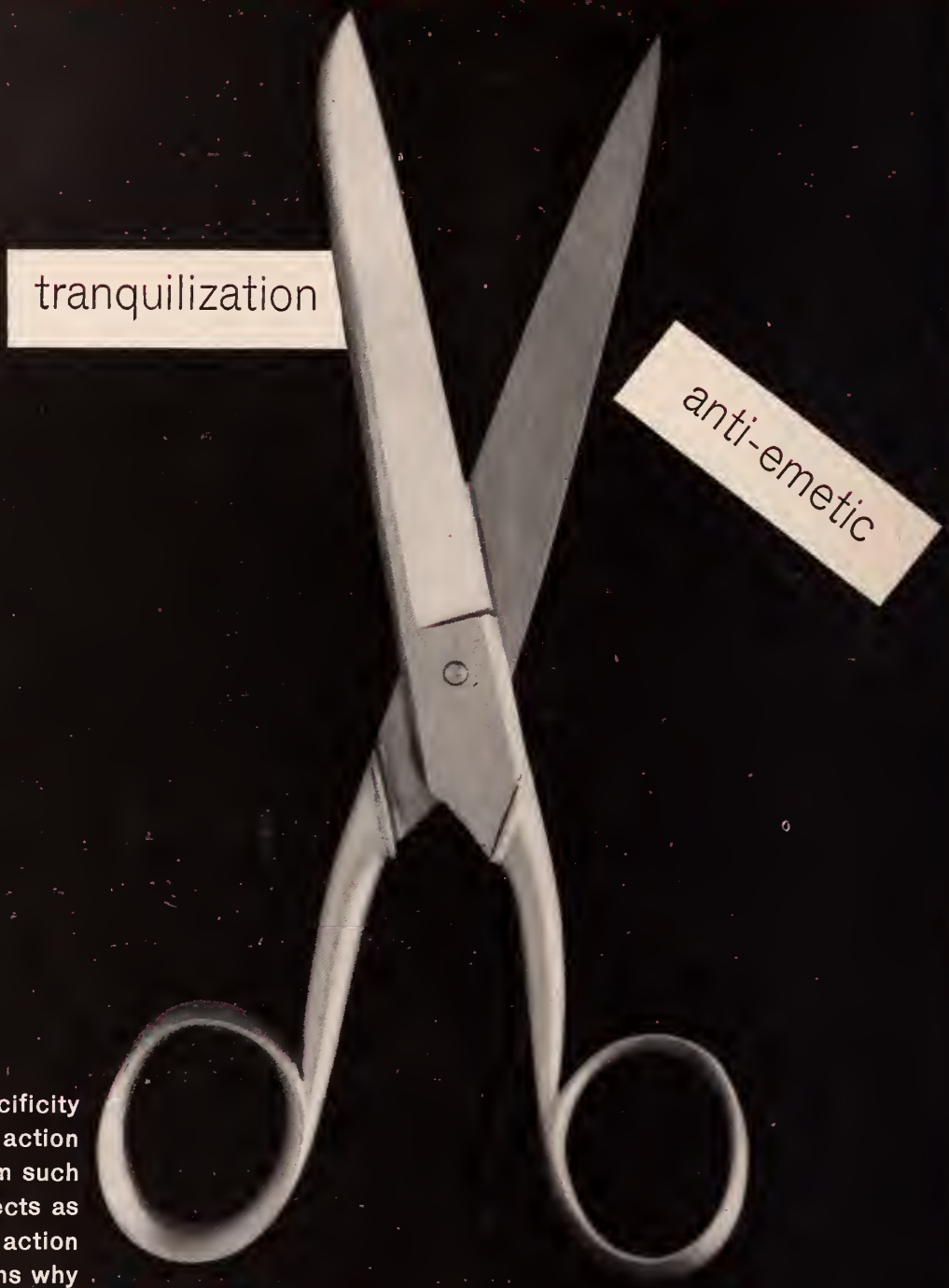
METI-DERM with Neomycin Aerosol—
50 Gm. container—16.6 prednisolone and 16.6 mg. neomycin sulfate.
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greater specificity of tranquilizing action —divorced from such "diffuse" effects as anti-emetic action —explains why

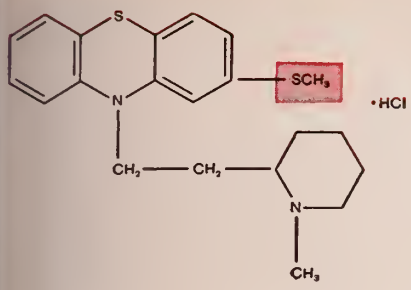
Mellaril®

THIORIDAZINE HCl

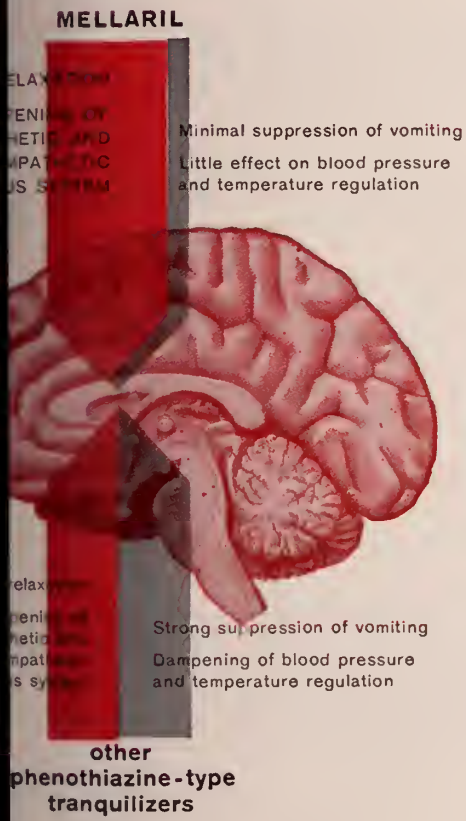
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscra

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreci less toxic effects than those demonstrated with other phenothiazines.... This drug appears to resent a major addition to the safe and effective treatment of a wide range of psychological turbances seen daily in the clinics or by the general practitioner."*

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er specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical ($S\text{-}CH_3$) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



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3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
LTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
DREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

IL Tablets, 10 mg., 25 mg., 100 mg.

Scientific Exhibit, American Academy actice, San Francisco, April 6-9, 1959

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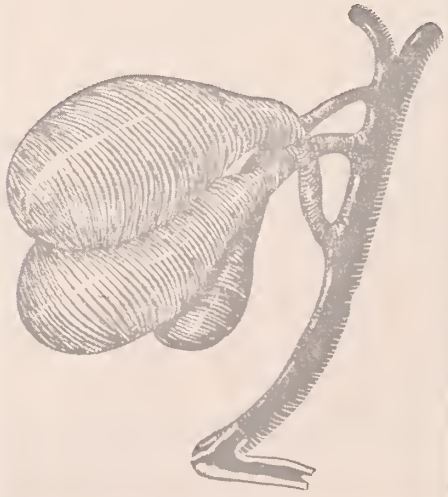
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Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



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free-flowing bile
plus reliable spasmolysis

DECHOLIN® WITH BELLADONNA

"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."[2]

(1) Beckman, H.: Drugs: Their Nature, Action and Use. Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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anti-inflammatory analgesic—
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of blood dyscrasias,
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THROPAN Liquid..."born of a therapeutic need"...The need was for a better antiarthritic agent—agent free of the therapeutic limitations and the discomforting or potentially dangerous side effects sociated with usual therapies...Under development for several years, ARTHROPAN has been studied several thousand patients by more than 180 investigators and is currently being evaluated in many ferent disorders...The rapid effectiveness, the comfortable and constant action, and the certain fety of new ARTHROPAN Liquid are established as clinical facts...ARTHROPAN breaks through rapeutic barriers and offers the arthritic patient new vistas in successful therapy of arthritis.

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day and night—ulcer control with **B.I.D.** *dosage*



Just one 10 mg. Daricon tablet in the morning, and one at night before retiring, keeps your patient free from the pain and discomfort caused by gastrointestinal spasm, hypermotility, and hypersecretion.

Daricon is a remarkably potent and well tolerated antisecretory/antimotility agent. Its *naturally* prolonged action provides day and night relief of pain and symptoms associated with peptic ulcer, functional bowel syndrome, biliary tract dysfunctions, and other gastrointestinal disorders characterized by spasm, hypermotility, and hypersecretion.

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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

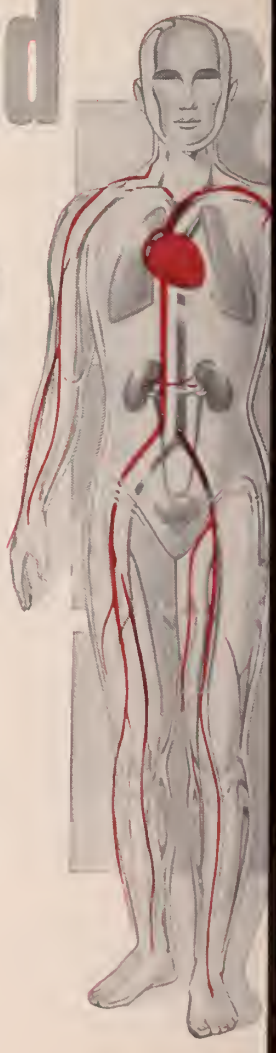
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(HYDROCHLOROTHIAZIDE)

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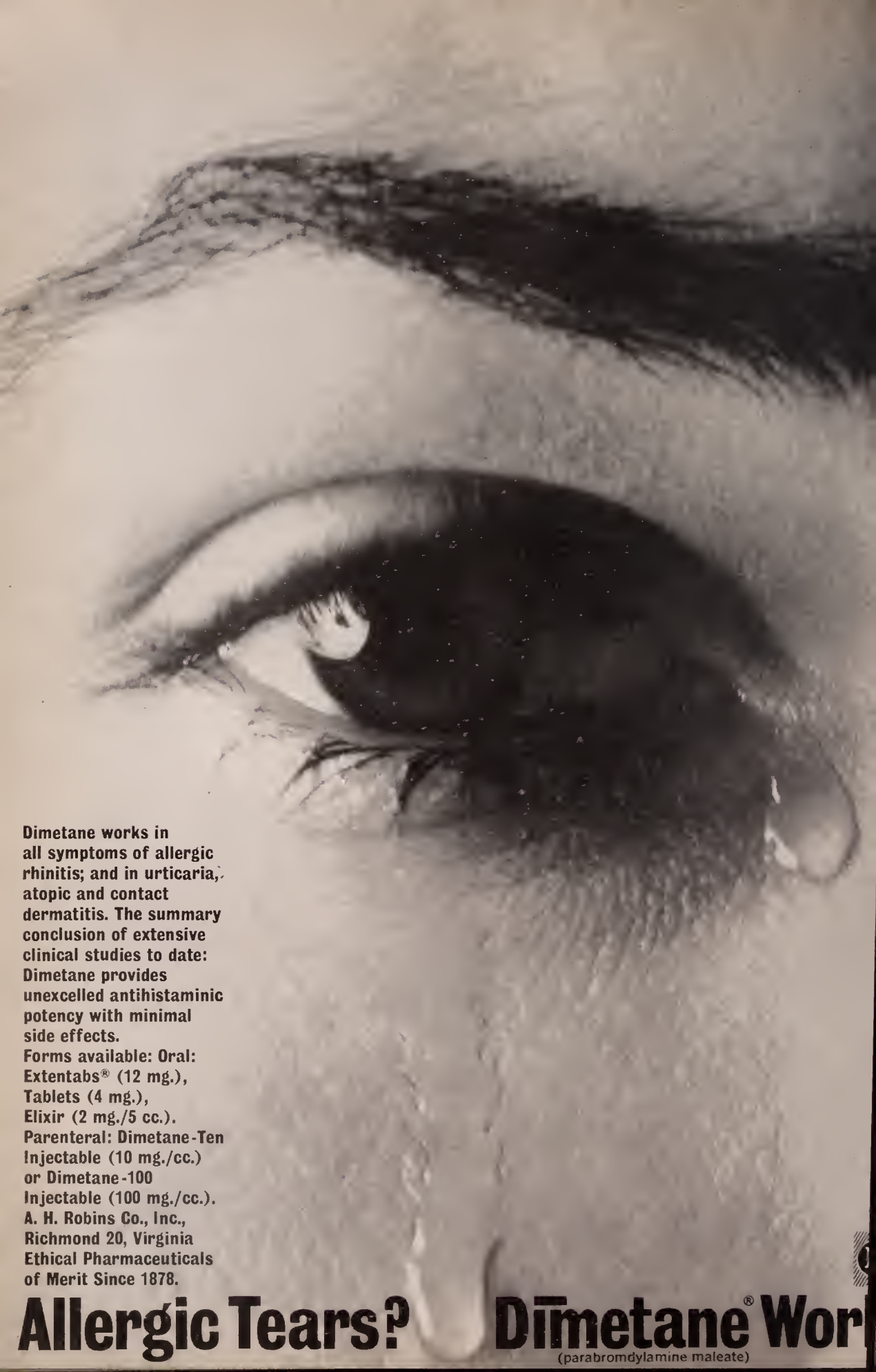
Add or adjust other agents as required: HYDRODIURIL enhances the activity of all commonly-used antihypertensive agents; thus, the dosage of other medication (rauwolfia, reserpine, hydralazine, veratrum) should be initiated or adjusted as indicated by patient condition. If a ganglion-blocking agent is contemplated or being used, usual dosage must be reduced by 50 per cent.

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Supplied: 25 mg and 50 mg scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000.
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Ethical Pharmaceuticals of Merit Since 1878.

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(parabromdylamine maleate)


Remarkable
relief from
low back pain and
dysmenorrhea
Trancopal
THE FIRST TRO[illegible]RANQUILAXANT

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can expe

prescrib

case profile no. 2758*

for low back pa



A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

hat you
hen you

THE FIRST TRUE TRANQUILAXANT

rancopal®

or dysmenorrhea
and premenstrual tension



case profile no. 3347*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

THE FIRST TRUE TRANQUILAXANT

Trancopal

potent muscle relaxant
effective tranquilizer

- In musculoskeletal disorders, effective in 91% of patients.[1]
- In anxiety and tension states, effective in 88% of patients.[1]
- Low incidence of side effects (2.3% of patients). Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

Musculoskeletal:
Low back pain (lumbago, etc.)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow, etc.
Myositis
Postoperative muscle spasm

Psychogenic:
Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism



Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

1. Collective Study, Department of Medical Research, Winthrop Laboratories.

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New York 18, New York



Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S Pat. Off. Printed in U.S.A. 6-59 (1385M)



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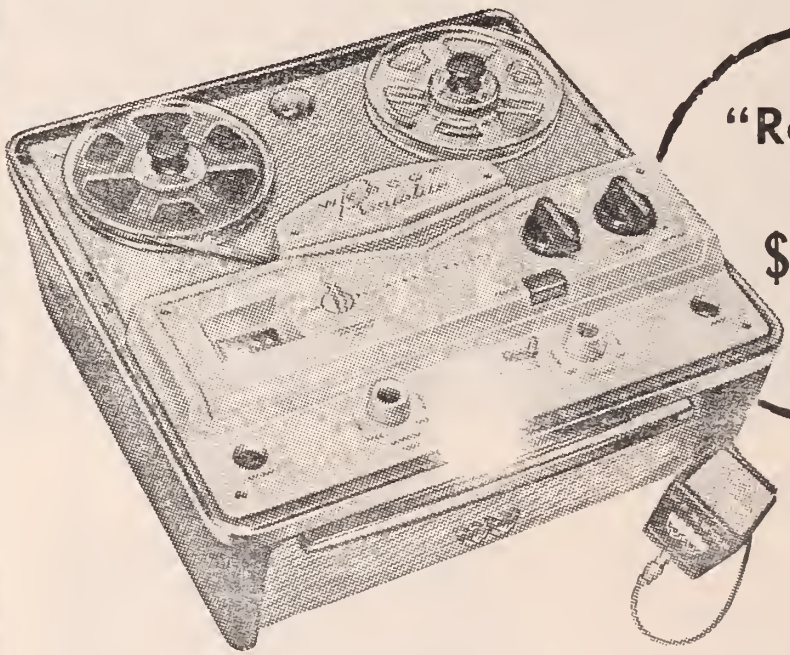
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OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.
OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.
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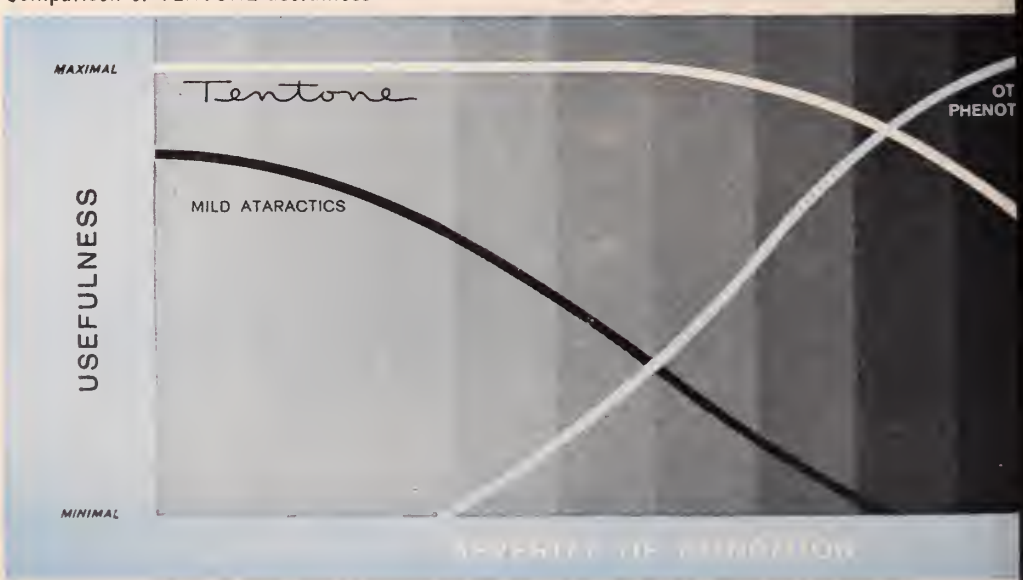


OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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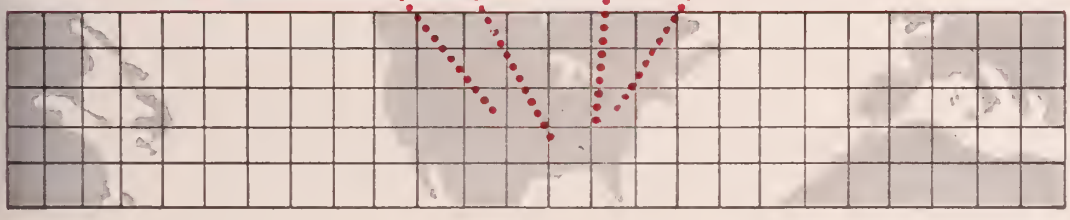
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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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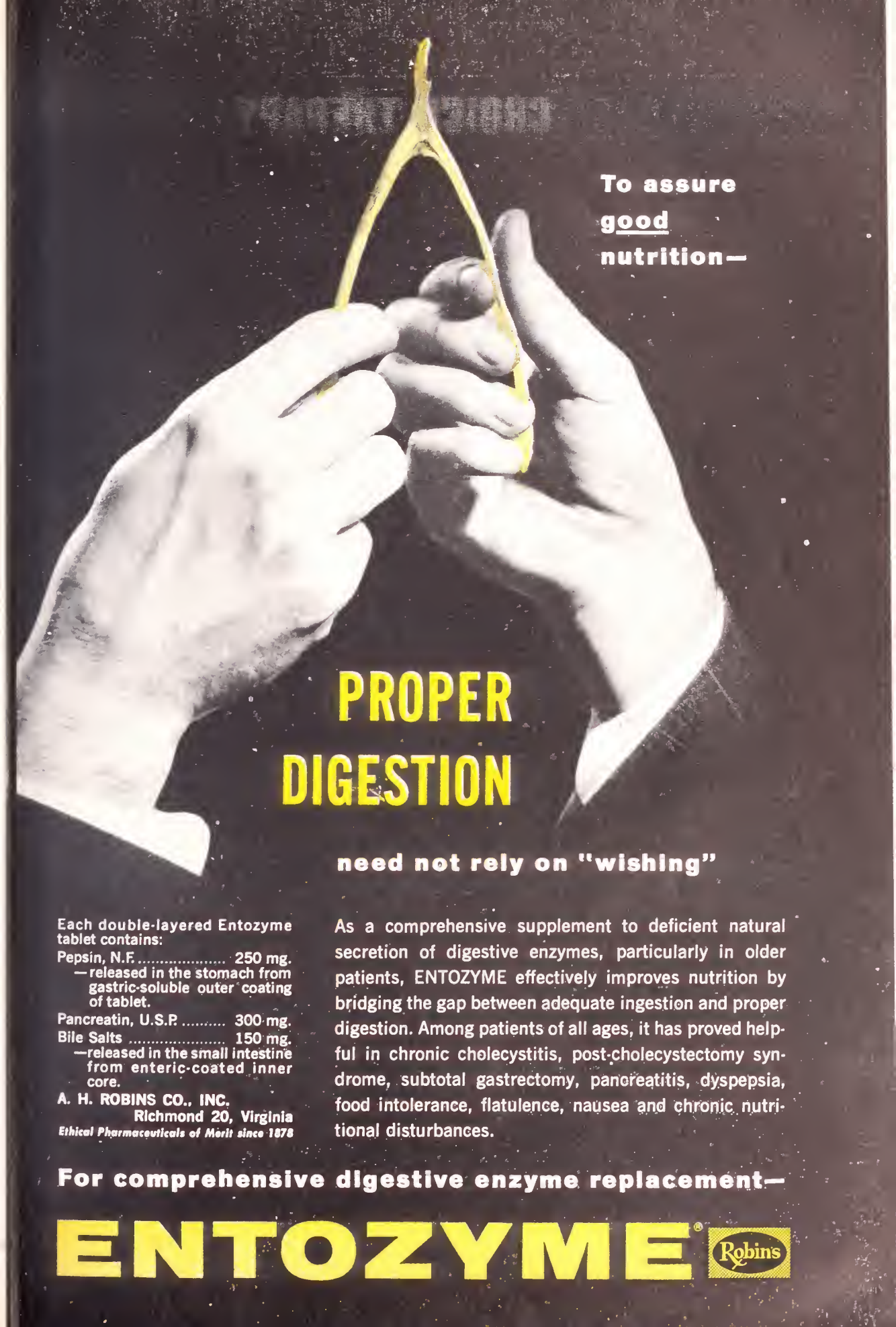
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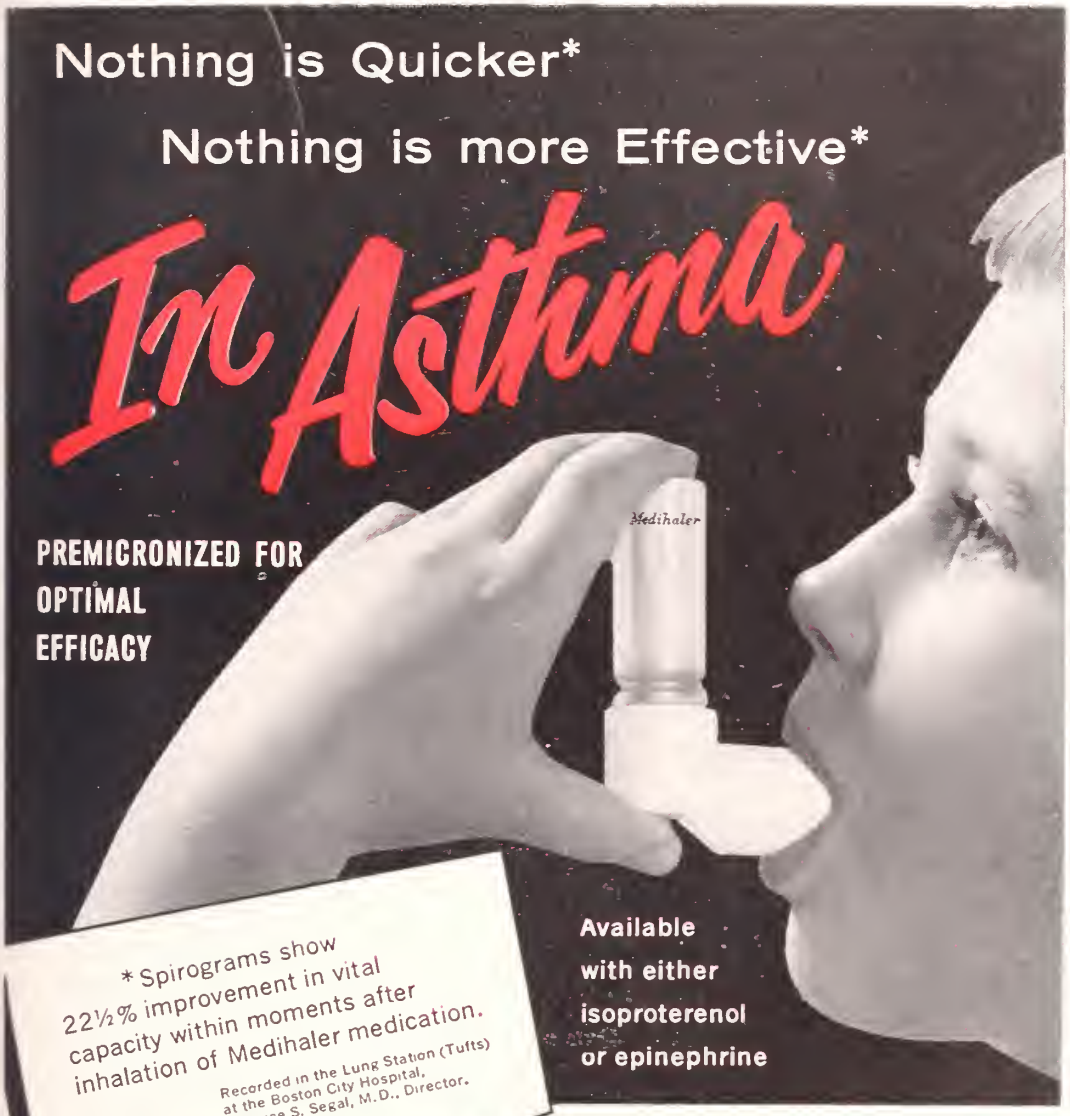
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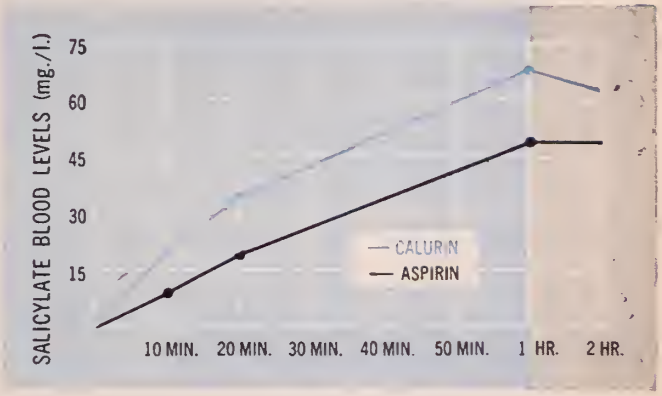
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CES· 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic ion of the effect of aspirin and certain other substances on the stomach, Lancet 2:1222, 1938. 3. Editorial Comments: The effect of licylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7, 1955. A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, une, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. 258:213, 1958. 9. Cronk, G. A.: ry and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. 258:219, 1958. 10. Editorial: Aspirin plain and Brit. M. J. 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium icylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, ton, D. C., Sept. 5, 1958.

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THE JOURNAL
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Editorials • • •

Taking Blood Samples from Incompetent Patients

The practitioner is asked, by the police, to take a blood sample from an apparently drunken driver. Suppose the driver, by reason of the intoxication, is incapable of exercising his right to refuse. Is the physician then guilty of an assault? Police surgeons in this state might do well to obtain a ruling of the corporation counsel or township attorney on this point.

Across the Hudson, a new addendum to the law, called section 71-A, provides that every person licensed to drive in New York, "shall be deemed to have given his consent to a chemical test of his breath, blood, urine or saliva for the purpose of determining the alcoholic content providing that such test is administered at the direction of a police officer having reasonable grounds to believe such person to have been driving in an intoxicated condition.

"If such person having been placed under arrest and having thereafter been requested to submit to such chemical test *refuses to submit to* such chemical test *the test shall not be given* but the commissioner shall revoke his license."

Writing of this, our contemporary, the *New York State Journal of Medicine* editorializes in its February 15, 1959 issue, as follows:

> Some prosecuting officers were of the opinion that it was proper for the physician to withdraw blood under such circumstances, since until there was an affirmative refusal by the driver the original implied consent continued.
>
> While counsel for the Society recognized the force of this opinion, in the absence of a decision upholding this position *he could not completely assure physicians it would prevail in a court.*
>
> The Supreme Court of the United States was called on (Breithaupt 352 U.S. Reports) to decide whether, in a criminal prosecution against a driver, the results of the test of blood withdrawn from the driver while he was unconscious were admissible at the trial. The driver contended that under the circumstances the withdrawal constituted an unreasonable search and seizure and violated his constitutional rights; hence, the evidence of the analysis of the blood sample should not have been received in evidence against him. The majority of the court did *not* uphold his views. It pointed out that the extraction of blood for testing purposes is an experience which, every day,

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many undergo without hardship or ill effects, and the purpose for taking the sample, under the various State laws, was for the protection of the public.

Three Justices dissented. *They regarded the taking of the sample as an assault committed on the unconscious driver* and spoke of the sample-taking as a violation of the sanctity of the driver's person.

Thus, while the Supreme Court held that the driver's constitutional rights were *not* violated and the evidence of the analysis was admissible against the driver, it did not expressly hold that the withdrawal of blood would not subject the physician to civil liability for assault. However, one could reasonably come to the conclusion, from the majority opinion, that withdrawing a sample of blood from an unconscious driver would *not* subject the physician to liability for assault.

The indemnity representative of the Medic Society of New York advises that the malpracti insurance of the Group Plan covers a physicia who takes blood pursuant to the request of a p lice officer under the Motor Vehicle Law.

It would be wise to have a formal typewritt consent to the withdrawing of blood by the phys cian, executed by the driver and witnesses. Th would be the best evidence that the driver co sented. However, *the statute does not require wri ten consent.* Express consent can be testified by witnesses. Consent can be implied from th circumstances testified to by witnesses. Under Ne York law:

No person except a physician acting at the r quest of a police officer shall be entitled to withdra blood for the purpose of determining the alcohol content therein.

The Discovery of the Aged

One of the odder features of today's medicine is the discovery of the aged. You would think that until the twentieth century no man lived to be 70. Old people have, of course, been honored and listened to in all climes and times. The Chinese almost made a fetish of such veneration. *Senator* and *veteran* (intended as words of respect) come from Latin words for "old." The adjective *venerable* suggests old age and is akin to the verb "venerate." The good adjective *sage* suggests elderliness too.

But to the American public this interest in the aged is something new. Perhaps it is a sign that our nation is becoming more mature. We have made a new branch of medicine out of our new interest in the aged. We have coined euphemisms to soften the harshness of the direct words. So we speak of "senior citizens" and "golden age" clubs. The American Medical Association now has a six-point program for "action by medicine in the field of aging." In brief, the six points are: (1) Get a realistic attitude towards aging; (2) Improve methods of financing health care for the aged; (3) Expand facilities for the aged; (4) Expand restorative and rehabilitative services for the aged; (5) Expand medical, social and econ omic research in gerontology; and (6) C operate in community programs for the age The AMA's Committee on Aging has pre pared a neat "Blue Print for the New Er of Aging."*

We have prepared golden merit award and silver medals and special ceremonies t honor our older colleagues. We are askin health insurance officials to be more generou in covering the aged—and our brethren to eas the economic burden of caring for the healt of the elderly.

In all these, medicine is something of laggard. Labor unions have long bowed lo before the altar of seniority. Judges are, b and large, expected to come from the rank of the older lawyers. Special and tender car awaits the elderly clergyman. In Europe a ma cannot expect to be chosen a professor unti he has matured into the sixth or seventh dec ade. In our country, a newcomer to a facult cannot aspire to a professorial chair unles he comes in before the age of 40 or 45.

And now, by some strange magic, the golde years seem to be valued as gold indeed. I has come to be recognized that (in Shake speare's term) age gives "the saltness of time."

*You can get a copy from the Council on Medical Service of the AMA at 535 North Dearborn Street, Chicago 10.

'e say amen to Thomas Parnell's *Verse to n Old Beauty*: "Let time that makes you omely, make you sage: the sphere of wisdom the sphere of age."

Not that we need live in a fantasy about his. We will remember one of the last aphorms of Hippocrates: "Old people have fewer diseases than the young. But their diseases never leave them."

Yet as Oliver Wendell Holmes sagely remarked on his 92nd birthday: "The runners in a race do not stop short when they reach the goal. There is a little finishing canter before coming to a standstill."

Funeral Director: Friend in Need

Physicians do not like the odor of the tombtone around their work and many doctors hy away from the persistent social and prossional contacts with funeral directors. This, owever, is unrealistic reasoning. Funeral dictors, as individuals, are no doubt jolly felws who make very good social companions. Iore important than that, however, the funral director can be a friend in need to the hysician not only at the time of a death among is patients but also as an ally in some of the loctor's legal, administrative and legislative attles.

To begin with, the work of the mortician s properly considered a professional activity. The funeral director needs skills in the emalming of bodies as well as in the complex peration of a modern funeral and the legal letails surrounding a death and a burial. The funeral director has to be recognized as a rofessionally trained individual.

The handling of a funeral requires considerable tact and delicacy. Funeral directors are, by and large, trained to exercise these qualities. It is common for the bereaved families to blame the doctor and they often cry on the shoulders of funeral directors. No one knows how often the mortician has assuaged the guilt feelings and has neutralized open or latent feelings of hostility against the physician.

The mortician is a great help in the preparation and validation of a death certificate. Many doctors can recall examples of how undertakers had to track them down and get the signature on the death certificate to prevent legal complications.

The funeral director who is well disposed toward the medical profession in general and the attending physician in particular will often delay the embalming of a body or detour bodies over long distances to facilitate an autopsy. Actually, funeral directors to a far greater extent than most physicians realize, help get permission for post-mortem examinations. One physician* has estimated that in his community the autopsy rate has gone up at least ten per cent because of the assistance of funeral directors.

In the antiquity of their calling, the morticians need not take a back seat to anybody. Embalmers had achieved professional status in Europe and Asia at a time when many branches of medicine were still at the stage of a skilled craft. Morticians have been the victims of an understandable prejudice against them because no one likes to be reminded of death. For this reason, they had been denied the professional recognition which has been awarded to dieticians, nurses, pharmacists and psychologists. Yet, when the chips are down, it must be conceded that the professional mortician is indeed a practitioner of a very ancient and skilled science. Mark Twain used to say that the sign of a good life was when even the undertaker was sorry that the man died. As usual, Mark Twain was a wise man.

*John D. MacCarthy, M.D., of Spokane, Washington, writing in the September 1958 *Bulletin of the Spokane Medical Society.*

F. Clyde Bowers, M.D.
Mendham

Lead or Be Led*

The presidency of The Medical Society is a singular honor conferred upon me by my colleagues which I am proud to accept. In doing so, I am not unmindful of the responsibility that it entails.

In becoming the 167th president of our Society, I am assuming a challenging task which has been well performed over the 193 years of our Society's existence by my many illustrious predecessors. They have given us a heritage which is rich in tradition and accomplishment. I shall take advantage of that heritage to the best of my ability in guiding the destiny of the medical profession in this State. Further, in accordance with our time-honored custom of devoting our services to the welfare of the people of New Jersey, I dedicate myself also to that end.

This is not a one-man job. Therefore, I call upon our elected officers, our committeemen, and each of our members for help and advice. Working together, with God's guidance I am sure that we shall sail a true course and shall safely weather whatever storms beset us.

For almost three decades now, the successive presidents of our Society have looked forward to their terms of office with a certain amount of misgiving regarding the future of the profession. Each one, almost without exception, has felt duty-bound to post storm warnings—and with just cause, I might add!

Why do we find ourselves in this continuous, uncomfortable situation? To answer this question it might be well for us to conduct a little self-analysis. I beg your brief indulgence while I attempt to give you a verbal portrait of a physician.

As the oldest of the learned professions, Medicine is necessarily steeped in traditions, chief of which is its concern for and devotion to the welfare of people and of society. Unquestionably, Medicine is also one of the most respected professions, a circumstance which makes all of us in the profession justly proud. In one extreme, the respect of the public has sometimes placed the doctor on a pedest where he has become the object of hero wor ship, where he has been looked upon as "a things to all men." In the other extreme, th doctor has been martyred because he dared t disagree with dogma, because he offered som new concept, or because he followed the cour age of his convictions in debate. Yet, Medicin lives on, despite flattery or persecution. Why Because the public demands it and the goo that it supplies and therefore supports it.

The public expects the doctor to be not onl learned but also compassionate, kindly, and de voted to his calling. It wants him to be friend, a father-confessor, a confidant. It ac cepts him as a leader, and therefore looks t him constantly for specific and authoritativ advice. To the public the physician is a gentl man with dignity of purpose, but he is mor . . . he is perforce an individualist—governe by his own ideas, ideals, convictions, and dedi cations—and thus he is the personification freedom. He could not conceivably meet th demands which are made upon him if he wer not free to offer opinions, to make recommen dations, to study and work as he sees fit, and in general, to mind and manage his own busi ness according to his own best judgment.

If the government or any organized grou subsidizes the physician, he becomes the pawn of that subsidizing agency. He is no longe free to dispense his services as he deem proper, but—even worse—the public is n longer free to look to him or call upon him a an individual. A system so enslaving the phy sician could possibly satisfy the basic scientifi medical needs of the community, but it woul be difficult for even the advocates of such a plan to deny that it would vitiate the presen concept of a physician, as previously described There is growing evidence that the public i not willing to make this sacrifice.

Now to return to our question of why w are constantly concerned about the future o our profession, let us examine the history o Medicine during the last thirty years.

I need not remind you of the great depres sion in the early thirties except to point out

*Inaugural Address, presented at the General Session, 193rd Annual Meeting, April 27, 1959.

that it gave birth to a social revolution. We had marches on Washington, and runs on banks, and many other demonstrations of public dissatisfaction and distress. It was at this time that the President established a Commission to Investigate the Cost of Medical Care. This was the first storm warning. Subsequently there came a series of bills—the Murray-Wagner-Dingell bills—each one proposing to place Medicine under government control. Next, England socialized medical practice, thus giving impetus to the efforts of socialistically-minded individuals in this country. Many different health bills designed to nationalize American Medicine were introduced and successfully defeated. Now we have the Forand Bill, which seeks to provide and pay for health care for our older citizens by expanding the Social Security program and fantastically increasing Social Security taxes. In addition, we have the multi-million dollar welfare funds of the unions which are being used to threaten the present status of American Medicine. It is small wonder, then, that during his tenure of office each president of our Society in the last three decades has shown profound concern over the future of our profession.

What gives rise to these things which challenge our present free enterprise system of medical practice? It is alleged to be the rising cost of medical care. The challengers are not impressed by our defensive answers. They are not interested in the fact that doctors' fees have not risen out of proportion to the increase in wages, to the increased cost of living, or to the rise in taxes. They are equally unconcerned about the fact that hospitals and drugs take the big slice out of the health dollar. They do not accept our logic that with the advent of newer drugs and newer surgical technics people get well sooner and, therefore, the proportionate cost is less. Their only interest is to make available "free" medical care to everybody. They wish to dispense something they do not have, and to pay for it with someone else's money. They neglect to see—or choose to ignore—that such tactics merely relentlessly send the inflationary spiral higher and higher, with ever increasing peril to our national economy.

Who profits and who loses by all this? If the proposed system of governmentally controlled services is honestly run, the physician is the only one who can gain, because he will have an assured income and probably will work fewer hours to obtain it. But at the same time he will be placed under bureaucratic control. This the physician does not want because, as an individualist and as a scientist, he dislikes and distrusts regimentation. He detests interference under all circumstances, not the least when offered by well-meaning but misguided people. He has fought for thirty years to sustain a free practice of Medicine—the type of Medicine which has made America the leader in the health profession. If American Medicine is subjugated by government the American public will lose an important element of its free enterprise system. It will be deprived of the type of Medicine to which it is accustomed and yet it will be obliged to pay inflated prices for the speculative advantages that the new system promises.

Well, is there any solution to this dilemma? Can we meet the demands of labor, government, and social planners and at the same time preserve the quality and character of American Medicine as we now know it? I think it can be done, but it will not be easy. Before we attempt to set down an answer, I think we must first decide what we want, and then how we may get it.

I am sure that everyone—the medical profession, the hospital association, the government, the social planners, and the unions—is truly concerned about the availability of good medical care for everybody. It is reasonable and commendable that all of us should be so concerned in order that our nation may continue to grow and prosper. Beyond this, we of the medical profession are motivated by humanitarian idealism to improve and maintain the health of our people.

From time immemorial the medical profession has devoted itself to the professional care of all people—regardless of level of income, and without expectation of compensation from those unable to pay. The first hospitals were constructed in this country solely to take care of the poor. As the practice of medicine and surgery began to demand hospital space for all sick people, the hospitals enlarged and provided many types of facilities, but they have always maintained wards and clinics for those who could not afford to pay.

Through these means—the free services of the physicians and the free beds and clinics in our hospitals—we believe that good medical care has been, and continues to be, available to everybody. With most people covered by some type of voluntary health insurance plans, which had their origins in medical societies and hospital associations, we believe that it is demonstrated that they can afford the available medical services.

This point of view is being challenged by government, labor, and others—possibly with some justification. Voluntary health insurance

has been accepted by the public and has grown by leaps and bounds in the past fifteen years so that now some 130,000,000 are covered by some type of health insurance. We believe this to be excellent progress, and although continuing inflation makes it difficult for our many health insurance plans to keep pace with the rising costs, continuous adjustments are being made to meet this demand.

From past experience we believe that these plans will be able to satisfy the needs of the public, but our critics are not content. They feel that there should be complete service coverage for all, but the schemes that they present are so far to the left of us that we cannot accept them. They claim that full coverage for all medical care can be provided only through compulsory health insurance by the government or through the welfare funds of the unions. This proposal is justified by our challengers on the grounds that good medical care is not available to everyone.

Since we are agreed that this—the availability of good medical care for all—is the ultimate objective which all factions seek, then it would seem logical to conclude that the solution is for us to reconcile our differences in a sincere effort to realize this objective.

Because bargaining at the conference table seems to supply the answer to many of our problems of today, I suggest that this method of approach be given a sincere and earnest trial. With the public as the arbiter, I believe we can reach a settlement, without humiliation for anyone. However, in order to reach a mutually satisfactory agreement, all parties will need to make certain concessions.

We, as physicians, can no longer sit in ivory towers, looking down at those about us and expecting them to accept our every suggestion without question. We should willingly meet at the conference table with our critics and our adversaries, to discuss our mutual problem without assuming patronizing or haughty airs. More than this, we should stop playing on the defense. We should assume the offensive by inviting representatives from interested groups to meet with us. There should be delegates from labor, management, government, hospitals, Blue Cross, Blue Shield, and commercial insurance companies.

From the outset it should be made clear to the negotiators that we will not sacrifice principles or ethics, that we will not tolerate intimidations or threats, that we will not surrender our freedom. At the same time, it should be made equally clear that we will listen open-mindedly to any reasonable proposal, because we do not consider ourselves to be paragons of success in the field of total health care, or oracles of wisdom in the field of finance. However, as the dispensers of medical care, we should let it be known that we expect these representatives to listen to and respect our opinions, to help us preserve our rights as free agents, if they sincerely want democracy to survive. In this way, we may effectively resolve our differences and evolve a plan which will insure the best total medical care that has yet been known to mankind.

I know that this suggestion is not new, but the proposed approach to the problem is different. We physicians should become the leaders in this fight, we should substitute positive thinking for defensive answers, we should recognize and deal with the complaint rather than deny that there are any grounds for its pronouncement. Furthermore, I feel that these negotiations should be at local level because there is great variance in custom and need in this vast country of ours. What might be good and satisfactory in one area may be absolutely intolerable in another.

In contemplating the future of our profession, it might be well to remember the circumstances attending the rise and fall of Greek civilization, as portrayed by Edith Hamilton, the well-known Greek historian. She states that in this first democracy in the world freedom was basic to all Greek achievement, and to this freedom she ascribes the success of the Greek civilization. By clinging to their desire to be free, the Greeks prospered and flourished, and made theirs the leading nation of their time. Contrariwise, when the Greek people decided that they wanted security and a comfortable life more than they wanted freedom, they lost everything, and their civilization collapsed.

This should be a great lesson for all of us in America who cherish freedom and independence. We should unite to defend and retain our birth-right and never permit any segment of our society to become enslaved by government.

In the sphere of health care the physicians of America must unite and rise up in defense of their independence and of the standards of their services, or be forever subdued. Since, in the parlance of the gridiron—and the battlefield, a "good offense is the best defense," we must take the initiative if we want to stay free. In other words, it is high time we recognize that we must lead or be led!

Mountain Avenue

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Camden

Staphylococcus Pneumonia*

Summary of Ten Cases

The staphylococci are not licked yet. As our antibiotics get better, the cocci become more resistant. Some forms of staphylococcic pneumonia have a mortality as high as 30 per cent.

The impact of staphylococcal infection in recent years has alerted the medical profession to the importance of this organism as a pathogenic invader. The challenge of the resistant staphylococci, the methods being used to meet the challenge, and the magnitude of the problem are portrayed in a mortality rate as high as 67 per cent.[1,2,3]

In September and October, 1957, Camden County was confronted with an outbreak of an unusual viral infection of the upper respiratory tract, generally considered to be Asiatic influenza. In November and December we began to see an increasing number of patients coming to The Cooper Hospital critically ill with pneumonia. Sputum revealed hemolytic staphylococcus aureus, coagulase positive. This paper concerns itself with the pertinent facts of ten proved cases, with one case reported in detail. One of the ten patients developed the pneumonia after an appendectomy. Ages varied from 22 to 82 years, with a mean age of 52 years. Only three of the patients were female. Three patients died, a mortality of 30 per cent. Eight were due to staphylococcus aureus, coagulase positive, two of which had positive blood cultures, and two were due to staphylococcus albus, coagulase positive. Of the three fatal cases, one had acute bacterial endocarditis, one was complicated by the hepato-renal syndrome, and the third died from primary pneumonia. Two deaths occurred in patients over 70 years of age. The third was under 40 years of age.

The initial symptoms were those of influenza. Ninety per cent had cough, with expectoration of thick, whitish-green sputum; 20 per cent had hemoptysis; 83 per cent had dyspnea and fever; 42 per cent suffered chills; and 6 of the ten were mentally confused. Ninety per cent of the patients had treatment prior to hospitalization, usually with penicillin.

Physical findings in the lungs were minimal when compared with the x-ray findings. Average leukocyte count was 12,000 in patients who survived, and within normal limits in those who expired.

The staphylococcus was found to be sensitive to erythromycin in 9 of the 10 cases, followed by chloramphenicol, novobiocin, and the tetracyclines a poor fourth. In half of the cases, the staphylococcus was completely resistant to penicillin. As described in the case report, erythromycin, 500 milligrams intravenously every 8 hours was the first antimicrobial agent given. The subsequent agents

*This work is from the "C" Medical Service of The Cooper Hospital, Dr. George Hare, Resident in Internal Medicine. This paper was read before the Camden County Medical Society, March 4, 1958.

used were administered according to sensitivity tests resulting from sputum cultures. Average hospital stay for our patients was 21 days.

CASE REPORT

A 22-year old woman was well until 4 days prior to admission, when she developed a sore throat. The following morning she felt warm, weak and dizzy. This was followed by a cough, productive of a thick, grey, odorless sputum. She soon suffered epigastric and lower substernal pain. This was sharp, constant, radiating around the right flank and was aggravated by deep breathing. She had received treatment 2 weeks previously for right lower quadrant pain and frequency of urination. Her history was otherwise negative.

Examination: The patient was a thin, pale



Figure 1. Day of admission. Area of pneumonitis involving the basal and lateral aspect of right upper lobe.

woman in acute respiratory distress, with flaring of the anterior nares. Temperature was 105.4 rectally, blood pressure was 100/40, and pulse 130 and regular. Respirations were 50 per minute, and shallow. Examination of the neck revealed enlarged cervical nodes. Pharynx was inflamed. On examination of the lungs, diminished tactile fremitus and dullness in the right mid-lung field were present, with increased breath sounds. No rales were audible. Her abdomen revealed muscular rigidity, epigastric tenderness, and hyperactive bowel sounds. The impression at time of admission was pneumonia, most likely staphylococcus, with possible intra-abdominal pathology.

Course: The patient was immediately placed in an oxygen tent, and isolation established. She was given acetylsalicylic acid every 3 hours. She was continually sponged with alcohol. Ice bags were placed in her axillae, and to her head. Following these procedures, her temperature dropped to 102 rectally, but then within hours returned to 104.6 rectally. At this time, erythromycin 500 milligrams intravenously was given every 8 hours, with a fall in temperature to 101 rectally. Intravenous erythromycin was continued for 3 days, at which time oral dosage was substituted. The patient's general condition then began to improve. Respiration and pulse were much slower, although pulmonary and abdominal findings remained essentially unchanged.

Three days following admission, her temperature remained at 100 rectally, but she continued to be toxic. Sputum report revealed the organism to be staphylococcus aureus, coagulase positive, sensitive to penicillin, chloramphenicol, erythromycin and novobiocin in that order. Penicillin and chloramphenicol were then started.

Following the addition of these antibiotics, she continued to have a temperature of 100 rectally for 2 days, but showed clinical improvement. On



Figure 2. One week after admission. Progression of lesion.

the seventh hospital day her temperature returned to normal, but with the onset of a productive cough, temperature rose to 102 rectally. Physical examination now revealed coarse rales in the right upper lung field. The patient, however, was clinically improved and out of oxygen.

On the ninth day after admission, the erythromycin was stopped and novobiocin was added to the penicillin and chloramphenicol. Her temperature returned to normal within 2 days and 7 days later all antibiotics were stopped. The patient was discharged 19 days after admission.

The staphylococci are Gram positive, nonmotile, non-spore forming, spherical cells occurring in clusters.[9] They are saprophytic and pathogenic.

During the growth phase of the staphylo-

cocci, exotoxins are liberated as hemolysins, leukosidins, fibrinolysins, hyluronidase, penicillinase and coagulase.[9] The classification as to pathogenicity based on pigment production is no longer factual. Many of the strains may become highly invasive. Strains producing the enzyme coagulase are considered pathogenic. Another method of differential study that is being used, predominantly research, is bacteriophage typing. The phage typing procedure is based upon the production during the growth phase of the organism, of a lytic substance that has specificity for particular strains of the staphylococci.[6,7,8] This classification is important because 60 per cent of the typable organisms of the hospital staphylococci group are phage type 52/42B/44A and 70 per cent



Figure 3. Two weeks after admission. Showing beginning of resolution.

of this phage type[5] show the same sensitivity pattern.[6] This means that most of the staphylococci falling in this phage type have the same antibiotic sensitivity, *viz*: resistance to tetracycline, streptomycin, and penicillin and sensitive to chloramphenicol, erythromycin, and bacitracin.[7] Typing thus becomes valuable as a therapeutic guide.

The organisms' primary reservoirs are the nasopharynx, skin and dust. Staphylococci are well adapted for cross infection in the hospital environment, remaining viable and even virulent in a dried state, on bedding and dust. Debilitation and crowding predispose to infection.[10] The difficulty in preventing and controlling infection by staphylococci is due to the organism's ability to adjust to life and growth in an unfavorable environment. Because of its primitive metabolic requirement and rapidity of growth, resistance often develops during antibiotic therapy. It has been suggested that the resistance of staphylococci is dependent on its ability to break down carbohydrates under aerobic conditions, the sensitive strain being anaerobic. This change from the anaerobic to the aerobic state can be brought about by subminimal concentrations of antibiotics.[11]

As seen in our case, the patient is usually critically ill, in a debilitated condition due to influenza, chronic disease or in a postoperative

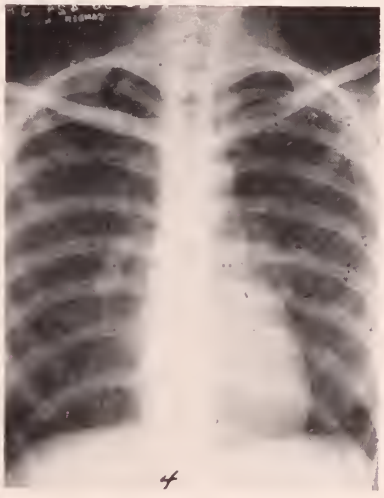


Figure 4. Day of discharge. Complete resolution.

state.[4] The physical examination shows little, and x-ray of the chest reveals patchy infiltration. In staphylococcic pneumonia, sputum culture is the key to the diagnosis and sensitivity studies the key to therapy. The literature[5] shows that the average age of patients admitted with staphylococcic pneumonia is 53 years. Duration of symptoms before admission averages 2 days to 2 months. The usual hospital stay is 3 to 4 weeks, average mortality being 20 to 30 per cent. The selection of drugs for therapy is guided by *in vitro* sensitivity studies.

Those working with this problem and its antimicrobial aspect are aware of the adapt-

ability of this organism. For this reason, we use massive dosage of the effective antibiotic, and also try many combinations.

SUMMARY AND CONCLUSION

1. We have presented the pertinent data concerning 10 proved cases of pneumonia, due to hemolytic staphylococcus. The case reported illustrates the usual hospital course of such pneumonias.

2. A bacteriologic discussion of the complex nature of the hemolytic staphylococcus aureus, and the value of phage typing is presented.

3. The complication of influenza by the hemolytic staphylococcus is being reported from various hospitals with increasing frequency.[12] The clinical picture is one of extreme morbidity which requires intensive treatment with the appropriate combinations of antibiotics.

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Pernicious Anemia

"A useful diagnostic test has involved the administration of cobalt-60 labeled vitamin B12 to patients suspected of having pernicious anemia. A patient with a metabolic defect of pernicious anemia will excrete an elevated amount of vitamin B12 in feces due to his inability to absorb it. Correspondingly, the amount of vitamin B12 excreted in the urine will be decreased relative to a normal patient. In the event such a test does indicate anemia, this may be checked by the administration of "intrinsic factor" which will temporarily restore the proper metabolism of the vitamin B12 and alter the urine and fecal excretions accordingly."—John S. Laughlin, Sloan-Kettering Institute.

How Old is an Infant?

The following comes from the November 30, 1958 issue of the *Federal Register*:

Regulations affecting special foods define an infant as a child not more than 12 months old. Apart from this, the Food and Drug Administration has not established any definition of the term "infant." Some question has arisen whether, for the purposes of drug labeling, an infant means a child up to 1 year of age or a child up to 2 years of age. Until the term is more precisely defined by legislation or formal regulation, where the exact meaning of the term is significant, manufacturers should qualify any reference to "infant" to indicate whether it refers to a child who is not more than 1 year of age, or a child not more than 2 years of age.

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The Use and Abuse of Medical Hypnosis*

Hypnosis, says Dr. Conn, is "nothing more than the suggestive influence of the doctor upon whom the patient depends for emotional support as well as for medical care. It is not a panacea."

Much of the interest in hypnosis today is associated with growing resistance to long term psychotherapy and with a refusal to accept Freud's dictum, that a neurotic patient can get well only by sweat, tears, and an expenditure of much time and money. There ought to be an easier way, some kind of short cut to the complex, technical, and personal problems involved in psychotherapy. The history of hypnosis, however, repeatedly has demonstrated that hypnosis has been destroyed, not by the excessive criticism of its skeptical opponents, but by the extravagant claims made by its overly enthusiastic proponents.[10]

There is no easy way to cure a severe neurosis. There is no short cut which will overcome the soul searing guilt of hostility or the painful canker of pathological jealousy. The patient needs time and the understanding support of a doctor with whom he can identify himself, before he can surrender his defenses and live comfortably without his neurotic encumbrances. This is just as true for the hypnotized patient as it is for the patient who is being analyzed.

The neurotic patient is afraid to think for himself. He is no longer capable of making decisions and of taking responsibility for what he says and does in every day living. He has developed a rigid, compulsive pattern of behaving in which anxiety has become the measure of what he can or cannot accomplish. He no longer can reflect or decide what to do on the basis of his past experience and the present life situation. He can use his neurotic tension only as a guide whether to remain where he is or make a hasty retreat, a flight to the safety of his home where he temporarily is free from being pointed out as the quaking, terrified, individual that he is.

If this is an accurate description of the average neurotic patient, how are we to account for the many "quick" cures which are reported in a number of current textbooks designed for the general practitioner? First, there are few long-term follow-ups. Only the successful cases are selected for publication. The many failures are seldom reported. All of us can recall a patient who seemed to be free of complaints after brief hypnotherapy who not long afterward, was being treated by a colleague.

Second, many patients insist that they are well (a flight into health) to avoid facing unpleasant personal issues which they might have to do something about. So they profusely thank the doctor for his "miraculous" cure and hurriedly depart, before any real insight can be attained.

*This work is from the Henry Phipps Clinic at the Johns Hopkins Hospital in Baltimore. The paper was read, by invitation, at Atlantic City, before the Annual Meeting of The Medical Society of New Jersey on April 28, 1959, Section on General Practice.

Neurotic patients are afraid to get well too quickly because they are not mature enough to live without gratifying dependent, infantile needs. They seek someone to cling to for support, sympathy, and guidance, and react by feeling guilty and hostile, if they are frustrated in their need to get closer and become more dependent.

Bertha B., an immature mother of two children, is unable to cope with a domineering mother, a passive, dependent husband, a phobic younger son, and an asthmatic older boy. She demonstrated her failure to master this situation by developing severe exhaustion and a feeling as if she were about to collapse. The patient recovered and was symptom-free after three hypnotic sessions over a period of three weeks. But she became more unhappy. When asked why, she said, "When I was sick I was the center of attention. My brother, who seldom came to see me, visited often and was interested in me. My mother was more understanding, and even my husband was helpful. I was happier when I was nervous than I am now. Now that I am well no one seems interested in me any more. I guess I got well too soon." A week later all of her symptoms had returned and it was two years before they disappeared again and she was able to live without her neurotic defenses.

Hypnotherapy, if it is to be accepted as one of the dynamic psychotherapies, cannot remain naive and unsophisticated.[10] It must learn to avoid the erroneous practices which have proved effective over a period of 50 years.[11]

The doctor cannot turn the therapeutic clock back to the time when hypnosis was the only way to help the neurotic patient. The patient cannot be coerced into getting well by any approach decided on in advance by the doctor. The patient will recover when he is ready and able to do so and the doctor cannot speed up the healing process by telling the hypnotized patient what is wrong or how to get well.[5]

Yet almost every recent book for the general practitioner extols the virtues of going back, far back, into the past and encourages the patient to emote melodramatically, to "abreact," as if this emotional release of past-traumatic memories will unconditionally or invariably be followed by a cure.

This reminds me of the story told by the television comedian, Sid Caesar, when he played the role of the Professor, who was seeking an explanation of his patient's chronic insomnia. "I made him go back, as far back, as he could in his memory," said the Professor, "until the patient remembered that when he was an infant, his mother had told him to open his eyes, and then had forgotten to tell him when to close them!"

If this appears humorous, let me tell you about the patient from the deep South, referred to me for the treatment of torticollis. He was a successful, ambitious, business executive who had "outgrown" his wife and was thinking of divorcing her. In several minutes after readily entering the trance state, his head became as straight as an arrow. The patient was aroused and permitted to see the "wonderful" cure in a mirror, but immediately expressed himself as being dissatisfied. "Why," he asked, "can you do this, and why can't I? I won't be satisfied until I can do it myself." As he departed for home, he asked me for the name of a book. I mentioned Karen Horney's *Neurotic Personality of Our Time*. The patient wrote to me several months later, that the book had contained a statement (which is untrue), that all that was necessary to effect a cure was that he "remember" an early trauma. The patient was pleased to report that he had succeeded in recalling an early trauma which had occurred at two, when he had a hernia operation and "almost died." "Certainly," he wrote, "that must have been a 'real' traumatic experience for a two-year old." He had been able to straighten out his head and to keep it straight, since he had recalled this traumatic event, and promised to come to visit me so as to prove that he was symptom free. A few months later he dropped in on his way to Washington to demonstrate that his head was "as good as new."

The recall, under hypnosis, of a single traumatic event or series of traumatic experiences (which often are spurious) is *not* invariably associated with cure. It, therefore, is wrong in principle and misleading in practice to begin by informing the patient directly or indirectly that he will recover as soon as he can recall certain "buried" memories. What usually happens is that the patient feels compelled to fabricate traumatic events in order to please the hypnotist. Hull[15] has shown that patients fabricate more readily under hypnosis than in the waking state. Each hypnotist obtains those psychological contents, which he has indicated to his patient as being the ones that interest him.

I used to wonder why certain hypnotherapists always report that their patients are vividly experiencing sex relations, acting-out their hostilities, and expressing themselves by sobbing and screaming, while my patients usually sit quietly talking about their actual life

problems with relatively little interest in the more melodramatic aspects of "acting out." After treating several patients, who previously had this type of experience with other therapists, I learned[6] that their "acting out" had been suggested to them as being the only way to get well.

The practitioner, therefore, must keep in mind that the value of emotional release (abreaction) lies not in itself, but in the fact that the patient (like my patient with the torticollis) is ready (set), able (is mature enough), and willing (unconsciously wishes) to get well and to stay well (that is, can maintain realistic goals). Only then can the patient endow the therapist of his choice (the transference object) with the power to cure him.

HYPNOSIS like penicillin should be used discriminately and always with the *full* consent of the patient. Some time ago I readily hypnotized an apparently compliant patient, who had been successfully treated hypnotically during a previous illness. However, on this occasion no progress was made and soon he broke off treatment with no explantion. Later he returned after having had electroshock therapy. This only increased his anxiety and phobic state. He then informed me of the severe tension which he had experienced during each hypnotic session. He explained that he had not complained because of his neurotic fear of offending me and asked, "Don't you *talk* to patients any more?" I reassured him that I did, and then treatment could proceed in a way which was better adapted to the patient's needs and not to my own preconception of what the treatment should be.

The general practitioner should always begin by using waking suggestion. Certain patients are *more* suggestible when fully awake.[13] The doctor who tells a patient, "You are beginning to look better. You are one of my *best* patients and I expect you to improve even more during the next two weeks," is bringing "new life" to his patient. A recent study of glaucomatous patients by Berger and Simel[1] demonstrated that intraocular tension was reduced more effectively when the doctor directly told the patient, in a sincere manner, that his headaches would disappear and that his eye condition had improved, than when suggestions were given either while the patient was under hypnosis or posthypnotically.

Some patients are most suggestible when asleep, and others respond best to suggestions in the light stage of hypnosis. A patient may develop a somnambulistic state and still may not respond to suggestion if he is not properly motivated. Wolberg[20] tells of a doctor who requested to be hypnotized to prepare himself better for the New York State Board examination. He was an excellent subject and all went well. On the day of the examination he called Wolberg and sheepishly confessed that he had not taken the examinations because he had overslept. His father had insisted that the patient take the examinations in New York, but the young man had a sweetheart in another state and preferred to take his boards in that state. He had solved the problem by oversleeping, after having consented to take them in New York to please his father.

Many patients are passive and remain silent as soon as they develop the specific interpersonal relationship which is the trance state.[3] These individuals should be told, "Enjoy being relaxed. You have nothing on your mind. That is good. Don't say anything until it comes to you naturally and without effort. What you say is not as important as how you act in keeping with your natural, real feelings. You can say nothing and get well, if that is what you want to do." In this manner[4] the patient is free to find his own way of expressing himself while in the trance state.

ONE of the recurrent problems is the patient who insists that he has not been asleep hence he has not been hypnotized. Hypnosis is not sleep—it is "imitation" sleep. I, therefore, inform my patient that hypnosis is *not* sleep and that if he wants to sleep to do it at home. "You come here," I say, "not to sleep, but to learn how to relax, and how to live more effectively, fully and without your present neurotic complaints." The patient in the hypnotic trance is not passive; he is an active agent who *uses* the doctor as the means of re-

storing the patient's feeling of mastery and control.[11]

In 1942, a young, married woman, whom I had interviewed several times asked: "Why don't you do something else besides talking to me? Why don't you hypnotize me?" I was willing to do so, but as I had never hypnotized anyone previously, I hesitated until the patient added the additional stimulus, which I needed by saying: "I know that you can hypnotize me, because my husband can do it, and he is not even a doctor." As my professional self-esteem was at stake, I held up my hand with an assumed self-assurance and before I had a chance to speak, the patient entered into the trance state; she had hypnotized herself.

This initial experience 17 years ago taught me humility. All I had done was to "set the stage," it was the patient who had satisfied a specific psychological need by establishing a specific type of interpersonal relatedness which was characterized by passive compliance and selective attention.

Thus, at the very beginning of my interest in hypnosis, I learned that anyone, even someone who was ignorant of the theoretical and technical implications of hypnosis can "hypnotize" a patient.

Even when the patient is skeptical, and says that he has no faith in hypnosis, it is how he behaves rather than what he says, which indicates the degree of his unconscious need for a regressive, compliant relationship.

The ideal patient is intelligent and able to concentrate on what is being said, and to believe that whatever the doctor says will happen, can and does happen. In brief, if the patient will look where you tell him to look, if he will pay attention, only to what you say to him, if he will become passive and let things happen, then he can be hypnotized effectively.

In selected cases hypnosis has been used to relieve pain in terminal cancer,[2] in severe burns,[14] and in minor and major surgery.[18] It is helpful in reducing anxiety in dental care[16] and obstetrics, and has been of value in the treatment of habitation, obesity, stuttering, and skin conditions.[19] Each individual must be evaluated in regard to his motivation, his secondary gains, and his ability to live comfortably without his neurotic "crutches." In psychiatric practice I have used hypnotherapy in the treatment of neuroses,[6] sex offenders,[7] and severe hysterical depressions[5] with some measure of success.

The psychodynamics involved in the hypnotic relationship can be summarized as a need to dominate or be dominated, a fear of authority which may be experienced as being destructive or dangerous, a fear of losing control of one's will, a wish to be stronger, a desire to be humiliated or overpowered, a conviction on the part of the subject that he will fail in the task of hypnosis, a need for dependency, expiation, or the feeling of guilt and terror of intimate interpersonal relations. Hypnosis may mean death, a homosexual relationship, or symbolize a rebirth fantasy.[12]

The hypnotist also must know himself, and not derive too much vicarious satisfaction or "power" from the treatment of the patient while in the trance state. He must be aware of the dangers of becoming involved in the patient's paranoid projections, of arousing repressed conflicts which may overwhelm the patient, of becoming the object of the sexual fantasies of the patient, or of removing symptoms in disturbed, unstable individuals who require their symptoms as defensive maneuvers.

THE dangers of hypnosis are those which accompany every psychotherapeutic relationship. Anyone who hypnotizes a prepsychotic patient without knowing what he is getting into is like the fool, who ventures where angels fear to tread. *Psychiatric training is an absolute prerequisite for intensive hypnotherapy.* The average practitioner should confine his hypnotic efforts to the preparation of the patient for surgical procedures, the alleviation of pain (analgesia and anesthesia) and postoperative comfort.[10]

The doctor continually is making direct and indirect suggestions to every patient. A negative physical examination suggests, "You can stop worrying." An injection suggests: "You are now being cured." and a prescription for a tranquilizer suggests that the neurosis is an organic disease, and that the underlying conflicts can be ignored (repressed).[17]

Every medical procedure includes the same fundamental ingredient: the personal worth of

the doctor. Hypnosis is nothing more than suggestive influence of the doctor, upon whom the patient depends for both care and emotional support, presented in a specific interpersonal setting. It is not a panacea for all the ills of mankind. If it is used discriminately for those who can endure living without their neurotic defenses, then in these *carefully selected* cases hypnosis can help to remove the functional overlay of organic disease, to relieve pain, to alleviate anxiety, and to facilitate the recall of significant traumatic events.

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A bibliographic list of citations appears in Dr. Conn's reprints.

Radioactive Phosphorus

"Radioactive phosphorus is rapidly incorporated in the cell nuclei particularly in those which are rapidly dividing and primarily in those in the bone marrow. Radioactive phosphorus is used to control polycythemia vera which involves the over-production of red blood cells. Since the life time of blood cells is many weeks and the P-32 is effective at their origin in the marrow its maximum effect after injection is not attained in the circulating blood for several weeks. Radioactive phosphorus is sometimes used for chronic leukemia to decrease the number of circulating white cells. Since P-32 concentrates in the liver, spleen and lymph nodes as well as in bone marrow, it is sometimes effective in this application. Radioactive phosphorus has also been used in the form of chronic phosphate, a colloidal solution, for the intracavitary treatment of pleural and peritoneal effusions. It is also employed successfully for superficial lesions where the finite range of its beta ray limits the therapy to the first few millimeters. The phosphorus is applied in an impregnated blotter or in a thin sheet of gelatin.

"These therapeutic uses of phosphorus-32 commenced with cyclotron-produced active material nearly two decades ago so that the therapeutic possibilities and limitations with this isotope are now well explored."—John S. Laughlin, Sloan Kettering Institute.

Trephine for Cerebral Palsy

Writing in the Dutch *Maandschrift voor kindergeneeskunde* (26:236), 1958, Biemond suggests that in cases of cerebral palsy, we are missing a bet by not trying harder to determine exact cerebral localization.

Before deciding what therapy is likely to be most useful, an extensive neurologic examination must be made, using all possible methods of examination. In this way the disease process can sometimes be localized, and this may lead to practical therapeutic measures.

When the extensive neurologic examination gives no certain results, experimental trephining may be indicated. To the present-day neurosurgeon, trephining is safe and may enable a subdural hematoma or hygroma to be removed. In infants with spastic hemiplegia experimental trephining is of special importance, and the earlier it is done the better.

In three such cases reported here, the final diagnoses were made by trephining. A subdural hematoma, a subdural hygroma and a localized microgyria with arachnoid ectopia of the brain tissue were found.

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Westwood

The New Look in School Health Programs*

Organized medicine should more seriously take its responsibilities in the school health field. While others share this duty, medicine should lead.

At present, a uniform School Health Program in New Jersey is practically nonexistent. Each community is an autonomous unit which operates independently of any other. In some other states, however, and in national organizations, the attitudes are significantly different.

This paper has been written to consolidate and summarize these attitudes and bring to the attention of the New Jersey medical profession, the fact that school medicine has been neglected by our local organizations and that certain faults now existing are the result of this neglect.

SCHOOL ADMINISTRATION

The success of a school health program rests with the school administrator. His initiative sets the program into operation, coordinates it, and informs the school personnel as well as the public, of its purposes.

The 5th National Conference on Physician and Schools (1955) presented data concerning school health records.[1] It was concluded that a complete health record should be kept on every pupil. The administrator should be in charge of these records and control their accessibility to authorized personnel. Access to agencies outside the school system should be made only with the parents' permission.

It is hoped that by keeping accurate records of a child's health progress, better care can be provided for the individual and group trends can better be followed and controlled.

NURSE

The nurse in the school is a vital link in the school health program.[2] She should not be used regularly for teaching but should be an advisor to the teaching staff. In most schools she carries out the screening tests so well described in *Health Appraisal of School Children*.[3] These tests screen out children needing further examination and diagnosis by specialized health service personnel.

TEACHER OBSERVATION

"The elementary schoolboy or girl spends more of his waking hours with the classroom teacher than with any adult other than his

*Submitted with the approval of the School Physicians' Committee of the Bergen County Medical Society.

1. Report, 5th National Conference on Physicians and Schools, 1955. Sponsored by The American Medical Association, Chicago.

2. Report, 4th National Conference on Physicians and Schools, 1953. Sponsored by The American Medical Association, Chicago.

3. Health Appraisal of School Children, second edition. Report of the Joint Committee on Health Problems in Education, of the National Education Association and The American Medical Association, Chicago.

parents. Thus the teacher occupies a unique position in relation to the pupil's physical and emotional health as well as academic accomplishments."[3]

All of the articles recommended the use of screening procedures under the guidance of teacher and/or nurse, to discover children with adverse conditions, either of physical or emotional nature. In his position of close rapport with the child, the teacher can often bring a problem to light in its incipiency. The literature emphasizes repeatedly the increase in emotional and behavior problems and their relationship to the rise in juvenile delinquency. The need for more preventive measures is obvious. The Report[4] of the 6th National Conference states: "Teachers can serve a useful role in the detection and direction of emotionally disturbed and maladjusted children. It is now considered by many that the maladjusted or disturbed child may be the predelinquent . . . We are hopeful that the solution of the problem of juvenile delinquency rests in adequate preventive measures . . . " In this program then, the teacher's perception of difficulties will be the initial impetus for further investigation.

SCHOOL PHYSICIAN

IN REVIEWING the available publications in this field, one cannot help but be struck by the recurrent theme of physician as a consultant, physician as an advisor, physician as an educator. At the present time in New Jersey, the use of the physician in a production line of (what are nearly always inadequate) physical examinations, is a real waste of ability and time. Every publication (including National and State organizations) recommends that the routine physical examination be done by the family physician whenever feasible.

Perhaps the best survey of the problem was given by Yankauer and Lawrence.[5] Dr. Yankauer is Director of the Bureau of Maternal and Child Health, New York State Department of Health. Dr. Lawrence is pediatrician for the Rochester Health Bureau. They set up a study in Rochester in 1952. Doing 2,263 examinations (lasting 30 to 40 minutes each including history) they concluded that the routine physical examination is a waste of time from a case finding point of view. The last paragraph of this report reads: "In brief, concentration of attention and effort to meet the needs of selected children who can be screened from the larger group by means other than a periodic physical examination, would appear to be a more constructive role for school medical personnel in elementary schools than a more general diffusion of their efforts." The health program should, however, be adequately flexible to take care of all schools—those which have pupils on a lower economic level who must depend on the school for medical care, and the opposite where only a few pupils will require examination in the school.

It is hoped that by creating a more productive and interesting school health program, physicians whose abilities and imaginations will contribute to its ultimate usefulness will be attracted to this field.

Menninger[6] states: "One child in ten among our 22 million school children now needs treatment for behavior disorder with 265,000 so disturbed that they are held in juvenile court." He believes that the family physician is far more skilled in this area than he realizes. He points out that of 9,500 psychiatrists in this country, only 170 deal exclusively with children.

The prevention of juvenile delinquency has become of prime importance in school health programs. School physicians must concentrate their attentions on this problem.

DENTAL PROGRAM

ALL the conferences agree that it is the responsibility of the school to teach the children the value of dental hygiene and to give

4. Report, 6th National Conference on Physicians and Schools, 1957. Sponsored by The American Medical Association, Chicago.

5. Yankauer, A. and Lawrence, R. A.: American Journal of Public Health, 45:71 (Jan. 1955); 46:12 (Dec. 1956); and 47:11 (Nov. 1957).

6. Menninger, W. C.: Mississippi Valley Medical Journal, 78:93 (1956).

instruction in proper dental care. *Health Appraisal of School Children* states that the most effective care results from encouraging the family to make regular visits to its dentist's office.[3]

VISION

SCREENING tests should be done annually on pre-school, elementary, and secondary school children. These are performed by the teacher or nurse and any child with deviation is referred for eye examination.[7]

HEARING

SCREENING tests for hearing are best performed by teacher or nurse. These should be done on the pre-school child and annually in the elementary school grades.

MENTAL HEALTH

THE 4th National Conference Report points out that a psychiatrist, used full or part time, or as a consultant, offers the best mental health program.[2] Psychologic testing has become a very helpful tool in the hands of skilled workers. One report[4] states: "Such tests should be conducted by skilled psychologists and psychometrists operating in an appropriate relationship to the health service department and available psychiatric personnel. The results of all such tests should be recorded on the individual health record card and be available to the physician who examined the child so that they may be included in the final appraisal of the physical and emotional health of the child."

For the most part, however, communities do not have the trained personnel available. Where psychiatric facilities are absent or inadequate, the communities should avail themselves of the trained assistance of psychologists. Working under the general guidance and direction of school physicians, a part or full time school psychologist can contribute significantly to the evaluation of problems.

SCHOOL PERSONNEL HEALTH

THE latest and most complete recommendations for school personnel care are given in the 6th National Conference.[4] Here it is recommended that the entire personnel—administrator, teacher, janitor, food handler, and even part time workers, have examinations prior to work and at regular intervals. The cost of these complete examinations, done by a private physician, are often partly or fully subsidized by the school board.

Work paper examinations should be done by the private physician or in clinics.

ATHLETICS

THE school health program in relation to school athletics is a vast subject and not within the province of this paper. However, several of the conferences showed that the required physical examination before appearing for each sport is somewhat superfluous in that the same healthy boy is examined as often as 6 times a year. They suggest yearly examinations except in case of illness or injury.

SCHOOL PHYSICIANS COMMITTEE

"PRIMARY general functions of a medical society school health committee are (a) to stimulate cooperation by individual physicians in the school health program; (b) to keep the profession informed on school health problems; (c) to encourage sanction by the medi-

7. Suggested School Health Policies, 3rd Edition, Jan., 1958. Prepared by the National Committee on School Health Policies. Published and distributed by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, Chicago, Ill.

cal profession of a sound school health program; and (d) to report to the profession on progress."[2]

ADVISORY HEALTH COUNCILS

"Because these are so diverse in organization, it is difficult to define or limit them. The following definition is accepted: An advisory school health council is primarily an organization to facilitate the exchange of ideas concerning the solution of health problems of children of school age. It may (a) recommend desirable school health policies, (b) assist with the implementation of such policies in light of local, immediate and future needs and available resources, and (c) aid in the evaluation of results of school health activities."[2]

Some counties in New Jersey do not have such groups. That they can be effective is shown by the example of the Liaison Committee on School Health in Bergen County. This group has, for the past 12 years, published a pamphlet on Recommended Minimum Standards for School Health Examinations[8] which has been one of the few advisory articles available to school physicians.

STATE CONFERENCES

In states which have had state and/or regional conferences on physicians and schools, the results have been gratifying.[2] The most productive ones have been initiated by state medical societies. Representatives from dental societies, medical societies, departments of education, departments of health, school boards, school administrators, P.T.A. and other volunteer agencies, have usually taken part.

SUMMARY

This article has extracted from the available literature the ideas representing the best in school health programs. When one sees the unanimity of opinion from the various states and national organizations, there can be little doubt that the ideas are valid.

The New Jersey School Health Program at both state and county levels, when compared with this program, is found to be grossly lacking. In a recent survey of the 21 county medical societies in New Jersey, only seven responded to the questionnaire and none had a county school health program. Because of the lack of recommended procedures from the medical societies in this state and in most counties, each individual school has established its own program. Occasionally these are very good but for the most part they are obscured in minutiae of routine procedures which are directed by someone other than the physician. The medical society has been remiss in assuming its proper role of guidance in school health matters. It is hoped that medical societies will assume a more active and responsible role in this important field.

A RECOMMENDED SCHOOL HEALTH PROGRAM IN OUTLINE

PURPOSE

To provide the best possible program for the health of the school child as suggested by National and State Conferences.

ADMINISTRATOR

1. To oversee the entire program.
2. To be in charge of the health record files.
3. To establish an efficient routine for school personnel to report, refer or care for problems.[9]

TEACHER

1. To establish pleasant working conditions for the children.
2. To observe and report significant abnormalities.

8. Recommended Minimum Standards for School Health Examinations. Prepared by the Liaison Committee on School Health of Bergen County, New Jersey. Endorsed and distributed by the Bergen County Superintendent of Schools, Hackensack, N. J.

9. Personal communication with Mr. Jose Rodriquez, Superintendent of Schools, Emerson, New Jersey.

NURSE

1. To perform the vision screening test at proper intervals.
2. Perform the audiometer hearing test at proper intervals.
3. Do height and weight measurements annually.
4. Assist the school physician.
5. Keep necessary records.
6. Provide assistance as consultant in teaching program.
7. Help as public relations person with P.T.A.
8. Act as health counselor.
9. Supervise first aid procedures.
10. Follow up remedial defects.

PHYSICIAN

1. Act as consultant for school health problems.
2. Have routine conferences with nurse and/or teachers on individual physical and emotional problems that arise in the classroom.
3. Provide health education for the faculty in conferences, educational material, *et cetera.*
4. Provide educational assistance for parents, for example, in an annual P.T.A. meeting.
5. For more serious problems, have conferences with nurse, teacher, psychologist and social worker, and parents when indicated.
6. Be a liaison between school and medical society.
7. Coordinate activities with P.T.A., service clubs and community organizations.
8. Perform complete physical examinations on children who cannot go to a family doctor.
9. Work closely with family physician on all problem cases, consult and utilize him as much as possible.
10. See that immunization procedures are carried out on children without a family physician. This can be done by clinics, boards of health and, if necessary, in the school.

DENTISTS

1. Encourage regular visits to family dentist.
2. Act as consultant to dental hygienist or dental assistant when available.
3. Conduct educational conferences with teachers or assistants.
4. Encourage use of fluoridation.
5. Arrange for care for pupils who cannot afford private service.
6. Act as liaison to dental society.

PSYCHIATRIST

If a psychiatrist is not available, a psychiatric social worker or a psychologist may be able to implement this part of the program.

1. Evaluate individual children through personality and psychometric tests.
2. Advise referrals to psychiatrists, mental hygiene clinics, guidance centers or other resources. If this work is in the hands of social workers or psychologists, the referrals should be in coordination with family doctor or school physician.
3. Participate in conferences about individual children.
4. Serve as consultant on appropriate subjects to school personnel.

10 Fairview Avenue

The Medical Care Dollar

The cost of medical care has been increasing sharply recently, according to the publication, *Patterns of Disease*, prepared by Parke, Davis & Company. Last year, the cost of medical care was 5 per cent higher than in 1957, a percentage increase exceeded only by the rise in transportation costs.

The publication also notes a change in the way in which a patient's medical care dollar is spent. *The physician's share of the medical care dollar has been declining steadily for the past few decades*—from 33 cents in 1929 to 24.5 cents in 1957. The amount spent on drugs has remained stable for this period, at 21 cents. However, the amount spent on health insurance and hospital care has doubled.

The number of persons entering hospitals annually has increased 150 per cent over the past two decades. During this period, length of patients' stay in all types of hospitals decreased 44 per cent. In general hospitals, length of stay dropped from 12.6 days to 8.9 days—a decrease of 29 per cent.

A. L. Cantelmo, M.D.

East Orange

Differential Diagnosis with Serum Alkaline Phosphatase Levels

In this unique paper, Dr. Cantelmo offers a ready reference guide to hepatobiliary diagnosis. While these tabulations will be helpful, the author properly warns against using them as blind diagnostic instruments. They will not substitute for history, laboratory studies and physicial examination.

Alkaline phosphatase in the organism was discovered by Robison in 1923 and is defined by Kolmer [1] as ". . . an enzyme capable of hydrolyzing the phosphoric ester of erythrocytes and plasma derived from hexophosphate, glycerophosphate and nucleoprotein with the liberation of inorganic phosphate." Phosphatase occurs in practically all tissues of the body. The phosphatase occurring in erythrocytes is different from that found in tissue, plasma and leukocytes.

Physiologically, alkaline phosphatase is formed in the osteoblasts of bone and released in the blood. It is excreted from the liver and intestinal wall into the bile. Logically, any excessive osteoblastic activity releases more alkaline phosphatase in the blood and any hepatobiliary obstruction forces bile into the blood stream with an increase of alkaline phosphatase. Herein is the diagnostic value of alkaline phosphatase determinations in humans.

The known normal serum alkaline phosphatase level is about 3 Bodansky units or 6 King-Armstrong units. In children, the levels are higher than in adults. A Bodansky unit is the amount of phosphatase equivalent to one milligram of phosphorus as the phosphate ion liberated from a phosphate substrate.

Alkaline phosphatase is elevated with increased osteoblastic activity and in many hepatobiliary diseases. This alkaline phosphatase activity must be differentiated from acid phosphatase which is formed only in the prostate and released to the blood in carcinoma of the prostate, especially if the latter has metastasized to the bones. In recent years, with the availability of a simple and reproducible test* for serum alkaline phosphatase levels, the interest and value of these determinations have been revived and have become more popular in everyday usage. Unfortunately, the literature is poor as to correlation and compilation of the test's general use in medicine.

The following tables, without oversimplification, attempt to bring together all the *known factors* involved in the use of serum alkaline phosphatase levels in diagnosis:

TABLE 1.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Abdominal tenderness		Cholecystitis
Bone pain		Cholelithiasis
Bone swelling		Hemolytic jaundice
	Normal (1.5-4 Bodansky units)	
Colicky pain		Necrosis of the liver
Eructations		Osteomyelitis
Jaundice		Periosteal tumors
Nausea		Traumatic hematomas of the periosteum
Vomiting		

*The materials used were products of the Warner-Chilcott Laboratories of Morris Plains, N. J. tradenamed as Phosphatabs® (alkaline) with Teswells®.

TABLE 2.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Anorexia Eructations Epigastric pain Nausea Vomiting Marked fatigue Marked exhaustion Mild to moderate jaundice Enlarged liver	Moderately elevated (About 10-15 Bodansky units)	Acute or chronic hepatitis

TABLE 3.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Ascites Abdominal varices Abdominal pain Loss of appetite Loss of weight Marked weakness Hobnail liver Enlarged spleen	High (About 20-24 or more Bodansky units)	Cirrhosis of the liver

TABLE 4.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Jaundice Ascites Upper abdominal pain Loss of appetite Enlarged, rough liver Previous diagnosis of malignancy	Moderately elevated (About 10-15 Bodansky units)	Malignancy of the liver (primary or metastatic)

TABLE 5.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Colicky pain in right upper quadrant Digestive disturbances Palpable gallbladder X-ray evidence of non-functioning or lithiasis of the gallbladder	Moderately elevated (About 10-15 Bodansky units)	Acute or chronic cholecystitis Cholelithiasis

TABLE 6.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Moderate jaundice Loss of appetite Digestive disturbances Pain and liver tenderness	Moderately elevated (About 10-15 Bodansky units)	Cholangitis

TABLE 7.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Deep jaundice Upper abdominal pain Loss of appetite Loss of weight Enlarged, tender liver Previous surgery Known maligancy Clay colored stools Bile colored urine	High (About 20-24 or more Bodansky units)	Common duct obstruction (complete)

TABLE 8.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Moderate jaundice Upper abdominal pain Loss of appetite Loss of weight Existing infection or lithiasis Previous surgery	High (About 20-24 or more Bodansky units)	Choledochitis (incomplete obstruction)

TABLE 9.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Bone pain (infants or children) Deformities of the skeleton Gastrointestinal disturbances (infants and children) Muscular weakness Beading of the ribs X-ray evidence of bone decalcification	Markedly elevated (About 30 or more Bodansky units)	Rickets or osteomalacia

TABLE 10.

F THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
ngle painful enlargement of the long bones -ray evidence of cystic disease of the bones athological fractures of the long bones revious history of syphilis	Markedly elevated (About 30 or more Bodansky units)	Osteitis deformans (Paget's disease) Osteitis fibrosa cystica

TABLE 11.

IF THE PATIENT HAS THESE SYMPTOMS	AND THE SERUM ALKALINE PHOSPHATASE LEVEL IS	THE PATIENT MAY HAVE
Multiple, painful swelling of the bones Pathological fractures Known history of malignancy X-ray evidence of bone pathology	Markedly elevated (About 30 or more Bodansky units)	Malignancy of the bones (primary or metastatic)

CONCLUSIONS

1. The value of serum alkaline phosphatase levels in diagnosis has been well established. This paper summarizes in tabular form relative activities of alkaline phosphatase levels. These tables will enable the busy practitioner to arrive at a faster differential diagnosis.

2. The value of these determinations is based upon complementary and supplementary history, physical examinations and other diagnostic laboratory studies.

3. The sensitivity of alkaline phosphatase determination in subclinical jaundice due to biliary obstruction should make this test a routine preoperative requirement for all hepatobiliary surgery.

144 South Harrison Street

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Eighteen Patients a Day

How many patients does a doctor see each day? The general practitioner carries the heaviest national average daily patient load—18.5 according to the publication *Patterns of Disease*, prepared by Parke, Davis & Company. The pediatrician has the next highest—17. Average number of daily patient visits for other types of practice includes 13 for E.N.T., 12 for obstetrics and/or gynecology, 12 for internal medicine, and 8 for psychiatry.

John P. Dirr, M.D., *et al.*

Riverton

Clinical Observations on Cerumenolysis with A New Pharmacologic Agent*

Any general practitioner who has struggl with the time-wasting, temper-trying, ear-irrita ing problem of impacted cerumen, will welcom the development of this new surfactant. If other can confirm these good results, a distinct forwar step will have been taken.

Excessive cerumen is a common problem in general practice. When excessive but of normal consistency, it obscures the tympanum, prevents an adequate otoscopic examination, and forces the doctor to waste precious time trying to remove it. Methods in current use may result in trauma to the external canal and even the tympanum, especially in children. If the cerumen is hard and impacted, it can give rise to a whole series of complications, many of which may be serious. Among these unpleasant sequelae are deafness,[1,3a] autophony,[2] reflex cough,[3] erosion of the osseous portion of the external portion of the external canal[5] and pruritus.[2] Vertigo is commonly seen[4] in cases of unilateral impaction and, when occurring in swimmers, may lead to panic and death.

Impacted cerumen may be hard to remove. The common pharmacologic cerumenolytics are largely ineffective, and instrumentation by pressure syringing and curetting can result in trauma and infection. Efficient pharmacologic cerumenolysis should lead to quick, atraumatic action. Administration should be simple and lead to easy removal of the cerumen. To fulfill these requirements, it should satisfy certain criteria:[7] (a) low vapor tension to pre vent excessive gas pressures within the ex ternal canal; (b) high viscosity, to facilitat the formation of a tenacious film on the sur face of the cerumen; (c) slightly acid pH, t maintain the skin's acid mantle; (d) low sur face tension, to allow the effective penetratio and consequent loosening of the ceruminou mass; (e) sufficient hygroscopicity to allo adequate mixing with transudates and exud ates; (f) low allergenic potential to preven sensitization of normal and pathologic tissue (g) adequate bactericidal and fungicidal ef fect to prevent cross-infection; and (h) lac of odor and taste, since it is to be used clos to the gustatory and olfactory areas.

A new cerumenolytic recently made avail able has been found to fulfill these physical chemical, and physiologic requirements as wel as the clinical requirements of efficient ceru menolysis. We here present our clinical ex periences with this preparation.

The new product is a surfactant: that is, a surface-acting agent. It is a condensate of tri ethanolamine polypeptide oleate in propylen glycol. It includes 0.5 per cent chlor-butanol as a bactericidal and fungicidal additive. The prod uct is made by the Purdue Frederick Com pany of New York and is tradenamed Ceru-

*Dr. Dirr is from the Zurbrugg Memorial Hospital at Riverside, N. J. Joint authors of this article are Dr. Harold Nimer of the Beck General Hospital in Passaic, Dr. M. J. O'Kane of St. Peter's Hospital in New Brunswick and Dr. John Meyer of the Mountainside Hospital in Montclair.

henex®. It is a 10 per cent solution.

Application: Cerumenex® is instilled in sufficient quantity to fill the ear and allowed to remain in contact with the cerumen for periods varying from 15 minutes to 7 days, in order to determine (a) the contact time of greatest effectiveness, and (b) whether any adverse tissue responses resulted after these periods. At the end of the elapsed time, the ear is gently syringed with lukewarm water and the results quantitated: complete removal of the cerumen is rated as good, partial removal as *fair*, no removal as *poor*.

This is a report of 82 cases, ranging in age from 5 to 75. About 15 per cent were under the age of 14. They were divided into the following groups according to the amount and consistency of the cerumen:

Group A: 54 patients with an *excessive* amount of *hard* cerumen *obscuring* the tympanum. This is 66 per cent of the series.

Group B: 7 patients with a *moderate* amount of *hard* cerumen *not obscuring* the tympanum. This accounts for 9 per cent.

Group C: 10 patients with an *excessive* amount of *soft* cerumen *obscuring* the tympanum. Twelve per cent were in this group.

Group D: 11 patients with a *moderate* amount of *soft* cerumen *not obscuring* the tympanum, accounting for 13 per cent.

In 31 cases (19 of group A, 4 of group B, 2 of Group C, and 6 of group D) the duration of contact with the cerumenolytic was 15 to 20 minutes.

In 41 cases (26 of group A, 2 of group B, 8 of group C, and 5 of group D) the duration of contact was 24 hours.

In 2 cases (1 of group A and 1 of group B) the duration of contact was 2 days.

In 7 cases (all of group A) the duration was 5 days. In one group A case, the duration was 7 days.

RESULTS

The results are summarized in the tables.

Of the whole series, 75 demonstrated good results, 3 showed fair results and 4 poor results. All 4 poor results fall in group A, the group most difficult to treat: 2 after 15 to 20 minute contacts, and 2 after a 24-hour contact. All required the removal of cerumen by curette. The best overall results were obtained on a 24-hour contact with the cerumenolytic.

The only untoward reaction observed was a local subjective pruritus in one patient who had had contact with the agent for 5 days. Prior to therapy, 7 patients had otitis externa and 5 otitis media. In none of these was any increase in pathology apparent after treatment with Cerumenex®. Three patients with deafness and one with vertigo and pain reported complete relief after easy post-treatment removal of impacted cerumen.

OVERALL RESULTS

Group	Cases	Good Results	Fair Results	Poor Results
A	54	49 or 90%	1 or 2%	4 or 8%
B	7	7 or 100%	none	none
C	10	10 or 100%	none	none
D	11	9 or 82%	2 or 18%	none
Total	82	75 or 91%	3 or 4%	4 or 5%

CONTACT TIME CORRELATED WITH RESULTS

		15 or 20 Minutes			24 Hours			2 to 7 Days	
Cases	Group	Good	Fair	Poor	Good	Fair	Poor	Good	Fair Poor
54	A	16	1	2	24	0	2	9	0
7	B	4	0	0	2	0	0	1	0
10	C	2	0	0	8	0	0	0	0
11	D	4	2	0	5	0	0	0	0
—		—	—	—	—	—	—	—	—
82		26	3	2	39	0	2	10	0

COMMENT

A COMPLETE removal rate of 93 per cent in the aggregate and 91 per cent in the difficult impacted cases represents an enviable result for any cerumenolytic; especially when only gentle irrigation with warm water is used to effect the final step. No other cerumenolytic method, physical or pharmacologic, has approached these results.

From the viewpoint of office routine, it is now possible to remove obstructing cerumin-

ous masses, which prevent adequate otoscopic examination, easily and without trauma in a matter of 15 to 20 minutes and certainly within 1 to 2 days, in most cases. Most patients with hard, desiccated impactions may be given a prescription for home use and asked to return within a day or two for removal. In either case, the saving of office time and patient discomfiture, represents a considerable increase in efficiency, particularly with children.

From the viewpoint of eradicating the potential danger of impacted cerumen, the markedly improved and atraumatic cerumenolysis reported here presents an easy solution to a hitherto troublesome problem. Other advantages are the lack of allergenic properties exhibited by Cerumenex® (which has also been reported by Rosnick[5] and Gant[8]) and the absence of further irritation in the face of pre-existing infection, reported by Bialkin[9] and Reiniger, *et al.*[7] Thus, multiple instillations and prolonged contact, when necessary, are not to be feared.

SUMMARY

1. A new cerumenolytic agent in 84 cases resulted in complete removal of cerumen in 93 per cent of the entire series, and in complete removal of cerumen in 91 per cent of those with hard, impacted wax.

2. In none was any tissue sensitivity or irritation demonstrated.

3. In 12 cases with pre-existing pathology (otitis externa and media), none showed evidence of aggravation.

4. Cerumenex® affords a simple and effective means of cerumenolysis, superior to any we had used previously.

411 Lippincott Avenue

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More Doctors Needed?

More physicians will be needed to keep pace with our population growth within the next two decades, according to *Patterns of Disease,* prepared by Parke, Davis & Company. In 1955, there were 132 physicians per 100,000 persons in this country. By 1975 the population will have increased to such an extent that the physician-population will drop below that for 1955.

To maintain this ratio, the equivalent of 20 new medical schools is needed. "Only in this way can the number of new physicians entering practice keep pace with expected population growth between 1955 and 1975," the publication states.

Henry Z. Goldstein, M.D.

Herbert E. Rickenberg, M.A.

Newark

Galvanic Skin Response Audiometry in Litigated Cases*

The conventional audiometer has definitive definite limitations in detecting malingered deafness. The galvanic skin response offers a relatively objective instrument which gives reliable hearing thresholds.

It is sometimes hard to determine a litigant's threshold of hearing because of his self interest. The subject's lack of cooperation may lead to gross differences of opinion by reliable examiners. Any modality that would give a more reliable threshold of hearing should be welcomed by otologists, whether they examine for the litigant or for the insurance company. Such a modality is the psychogalvanometer in association with a pure tone audiometer for the measurement of the percentage of hearing loss. As will be shown below, psychogalvanic skin response audiometry is a means of establishing the true threshold of hearing.

The Galvanic Skin Response (GSR) test as a means of measuring auditory acuity was first developed at the Johns Hopkins Hospital by Bordley and Hardy[1] to measure hearing in preschool children. The technic does not rely on the cooperation of the patient. Skin has a resistance to a flow of current. When resistance increases, the flow of current decreases and *vice versa*. The technic of utilizing skin resistance as a determinant in measuring auditory perception is possible by conditioning the patient. Conditioning is accomplished by associating a mild electric shock with the pure tone stimulus of the audiometer. After the patient is conditioned (6 to 10 trial periods) the pure tone stimulus is presented without the electric shock. The patient when perceiving the pure tone expects the "shock" stimulus and perspires in anticipation. The anticipation changes the skin potential thereby altering the resistance of the skin and in turn deflecting the recording apparatus of the instrumentation. In this manner the threshold of hearing can be ascertained objectively.

Figure 1 illustrates a modern psychogalvanometer.



Figure 1. Typical modern psychogalvanometer (Grason-Stadler Co., Model E664).

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1. Bordley, J. E. and Hardy, W. C.: Annals of Otology, Rhinology and Laryngology, 58:751 (1949).

istered and the results confirmed the conventional pure tone threshold.

CASE SEVEN

A 48-year old man stated that, after he started to work, he noticed that he perceived ringing in his ears which seemed to come and go. This subsided after he was away from work for a while. Six years ago he noticed that his hearing was getting worse. He had particular difficulty in hearing voices. A year or two later he was sent to a hospital for examination and tests. He alleged that he has been wearing ear plugs for the last seven years. In spite of the ear plugs he asserted that his hearing was getting worse and that he still had ringing in his ears.

Otologic Examination: At the time of examination, he was complaining of: (1) He can't hear. (2) Ringing in the ears worse in the right ear. While giving his history, he seemed to hear raised conversational voice at about five feet distance. There was no spontaneous pastpointing, nystagmus or falling. Transillumination revealed clear frontal sinuses but some diminution of both antra, especially the right. Neither auricle, external auditory canal or ear drum showed evidence of any trauma. Both ear drums were clear, intact, moderately retracted and showed scattered areas of fine atrophy.

Audiologic Examination: In the audiometric examination he acknowledged a severe bilateral hearing loss. A GSR was administered and the results indicated a slight exaggeration at 250 and 500 cycles per second, but otherwise confirmed the conventionally obtained audiometric.

SUMMARY

IN THE first four cases, here reported, the psychogalvanic skin response (GSR) in audiometry ascertained the threshold of hearing in malingerers. The last three cases indicated the use of GSR-audiometry in confirming hearing losses in cooperative patients.

The GSR-audiometry technic is not a panacea in industrial otology. However, when used as suggested, it does offer an excellent means of authenticating controlled responses.

Authors' reprints contain 14 audiograms.

31 Lincoln Park (H.Z.G.)
77 Central Avenue (H.E.R.)

Is Buerger's Disease a Myth?

Thrombo-angiitis obliterans has been so diagnosed since the turn of the century. But a group at Harvard Medical School now say that there is no such condition. This thesis was presented at the Annual Meeting of the American Association of Pathologists in Boston. The opinion is based on three years of study by David G. Freiman and his associates of Beth Israel Hospital and Harvard Medical School.

What was once diagnosed as Buerger's disease and resulted in blocking of the arteries in the extremities, the investigators suggest is due to the formation of clots in the arteries or to atherosclerosis.

The report is based on studies of 123 consecutive patients admitted with a diagnosis of Buerger's disease. These were compared with 1365 patients with other forms of arterial disease admitted in the same period. During this period, as demonstrated by a study of the diagnostic records of the patients involved, the diagnosis of Buerger's disease steadily declined. *After* 1949 *no new cases of thromboangiitis were diagnosed at Beth Israel.* "This," the authors stated, "suggests increasing reluctance on the part of physicians to make the diagnosis on clinical grounds alone."

John A. Sakson, M.D.

Camden

Omental Infarction

Right-sided abdominal pain suggests appendicitis or cholecystitis. And on the theory of "think of the commonest first," this is usually correct. But sometimes a rare lesion like omental infarction can plague the doctor. Here is one of the very few papers on this subject.

Omental infarction is a relatively infrequent disorder which may mimic many other intra-abdominal conditions. It most commonly simulates acute appendicitis and acute cholecystitis. During the past three years, 12 patients have been operated on for omental infarction. In only one of these was it mentioned as a possibility in the pre-operative diagnosis.

Infarction of a segment of the greater omentum follows no set pattern. The history is one of a gradual onset of pain, usually on the right side of the abdomen, with no history of trauma or exertion. In every case in our series pain was on the right side of the abdomen. This is in accord with Shea's report* in the *New England Journal of Medicine*. He reviewed all 43 reported cases of segmental omental infarction up to and including 1956. Only two of the 43 complained of pain on the left side of the abdomen. This pain is constant, not intermittent, and varies from an aching sensation to a moderately severe episode. Typically it begins in the area of the lesion. It does not change its location, although it might radiate into the back or into the upper and lower quadrants of the abdomen. The area where pain was felt was usually the most tender spot, and associated with only ipsilateral rebound phenomena. The tenderness in these patients seemed so superficial that it usually gave one the impression of cutaneous neuralgia. Elevation and compression of the skin gave almost the same response as light pressure over the affected area. Peristalsis in all 12 of our patients was normal.

All patients felt some nausea. In none was there any vomiting either with the onset or the pre-operative course. In half the cases the temperature was slightly elevated (never above 99.4). In the remainder, temperature was normal or slightly below. The white blood count was above 10,000 cells per cubic centimeter in only two cases, varying from a low of 4,500 to a high of 20,000 white cells with an average of 8,700 white cells per cubic centimeter and a 70 per cent neutrophilia on the differential count.

In only three of the 12 was there history of previous surgery. Males and females were equally affected. All 12 were either well-developed or had a tendency toward obesity. Our youngest patient was 26: our oldest was 76. Except for Case 2, all were Caucasians.

Case 1: A twenty-six year old male began having dull, aching pain in the right lower quadrant of the abdomen while eating. It was not relieved by positional change. He became nauseated at this time, but did not vomit. Upon admission to the hospital 14 hours later there was noted tenderness in the right lower quadrant with rebound tenderness also present over the area. No masses could be palpated. Temperature was 97.2; pulse 100 beats per minute; the while blood cell count was 4,550.

*Shea, C. J., Pomer, F. A. and Spellman, J. W.: New England Journal of Medicine, 254:263 (Feb. 9) 1956.

The diagnosis of atypical acute appendicitis was made and operation was done two hours after admission. Over the cecum was found a hemorrhagic area of omentum about 3 by 5 centimeters, attached to the anterior peritoneal wall. The appendix was edematous, but otherwise did not seem to be involved. A segment of omentum was resected and appendectomy done. Pathologic report showed no white blood cells in the lumen of the appendix, but some edema of the serosa. The omental specimen showed areas of hemorrhage and fat necrosis associated with extensive inflammatory reaction. The final pathologic report was omental infarction.

Case 2: A seventy-year old woman was admitted with complaints of pain in the right upper quadrant associated with nausea, but no vomiting. She gave a history of frequent belching with mild intolerance to fatty foods. She also had frequent episodes of dull, vague pain in the right upper quadrant. She was a well-nourished, well-developed woman who looked 10 years younger than her age. She had exquisite tenderness in the right upper quadrant with rebound. A positive Murphy's sign was elicited. Temperature was 98.4; pulse 80; white blood cell count 5,200 with 72 per cent neutrophiles. The diagnosis was acute cholecystitis and effort was made to treat her conservatively. Pain gradually increased in intensity and on the next day she was markedly worse. Surgery was then decided upon. A right rectus incision was made and exploration of the abdomen performed. Under the edge of the right lobe of the liver a hemorrhagic area was found involving a piece of omentum, 3 by 4 centimeters. It was adherent to the top of the gall bladder. This was dissected free and the gall bladder was found to be perfectly normal in appearance. So was the appendix, which was then removed. A resection of the segment of omentum was carried out. Pathologic report showed the omental specimen to have areas of fat necrosis, focal areas of thrombosis and hemorrhage. The final diagnosis was omental infarction.

Case 3: A 42-year old man was admitted with pain in the right upper quadrant present for 48 hours prior to admission. He noticed the pain for the first time while at work during the afternoon. It had gradually increased until the patient could not hold any object against the abdomen. There was no history of trauma or unusual exertion. He was nauseated constantly, but had not vomited. No further history relative to the case was elicited. He was a well-nourished, well-developed man, uncomfortable, but in no acute distress. There was an area of extreme tenderness to the right of the midline in the right upper quadrant of the abdomen. Muscle guarding and splinting were also noted. A definite mass could not be palpated. Temperature was 93; pulse 86; the white blood cell count 9,600. Hemoglobin was 13 Grams with a hematocrit of 42 per cent. At x-ray, the gall bladder was found to be normal. Barium enema revealed a partial obstruction of the right transverse colon simulating a "napkin-ring" lesion with the appearance of a carcinoma. Laparotomy revealed a mass of hemorrhagic omentum bound down on the right transverse colon some 6 centimeters from the hepatic flexure. The colon in this area was red and edematous. Omental dissection was then begun prior to a planned obstructive resection. However, the omentum was found to be only markedly adherent to the bowel. The colon under this was completely normal with no evidence of carcinoma or diverticuli. A segment of omentum measuring 6 by 8 centimeters was then resected. Pathologic report showed typical findings of omental infarction. The postoperative course was uneventful and the patient was discharged on the tenth day.

SUMMARY

(1) Infarction of a segment of omentum can mimic other intra-abdominal lesions. Most frequently it simulates appendicitis, and less frequently cholecystitis.

(2) Pain is always present. It is dull, aching, and constant in location and duration.

(3) Tenderness is invariably present over the infarcted area and is associated with the rebound phenomenon. This tenderness is unusually superficial.

(4) Nausea is present in all cases, but it is not associated with vomiting. There is no change in bowel habit.

(5) The white blood cell count is rarely elevated over 10,000 cells per cubic centimeter, but does show a prominent neutrophilia.

(6) Omental infarction is not associated with other intra-abdominal conditions.

(7) The diagnosis of infarction of a segment of omentum should be entertained in all cases of right sided abdominal pain if the signs and symptoms do not readily point to a more common specific disease.

The Cooper Hospital

Celestino Clemente, M.D.

Glen Ridge

Pelvic Abscess Following Ruptured Appendicitis in Children

As bacteria become more resistant to our new antibiotics, pelvic abscess will become a more common complication of ruptured appendicitis. Dr. Clemente here suggests a conservative approach to this problem.

Pelvic abscess following appendectomy in children has not received great attention in the past twenty years. This is probably due to a marked decrease in incidence aided by the widespread use of antibiotics following operations where peritoneal soilage has occurred. But, it is my feeling, however, that we may be entering an era when the *contre coup* of the blessings of the "miracle drugs" may be felt. Recently, much has been written about cutaneous and wound infections caused by resistant strains of staphylococcus and streptococcus. The same phenomenon of resistance development will give us greater and greater problems in cases where there has been soilage of the peritoneal cavity with the patient's own intestinal flora. This will be especially true in children where oral broad spectrum antibiotics are commonly used for the frequent respiratory infections of childhood.

In reading some of the standard textbooks on general surgery, one gets the impression that pelvic abscess is a more frequent complication of ruptured appendix prior to appendectomy. Maingot [1] recommends that a pelvic abscess be allowed to localize, and that it be drained through the vagina or rectum. He says "that in most cases the convalescence is speedy and uninterruped but appendectomy is best deferred for a period of six months, not three months as is so frequently recommended." He does not mention pelvic abscess in discussing postoperative complications.

Deaver and Martin [2] state that once the surgeon makes the diagnosis of pelvic abscess following appendectomy, immediate surgical drainage should be instituted. They do not say whether the cases occurring in children should be handled differently from those in adults.

Gross [3] makes the following statement with regard to pelvic abscess following ruptured appendicitis. "If an abscess appears in the pelvis, no attempt should be made to open it through the rectum until definite fluctuation is detected by digital examination, and until the mass is large enough to impinge upon the adjacent pelvic nerves and paralyze the anal sphincter. The low lying collection of pus often spontaneously ruptures into the vagina or the rectum; the resulting wound heals with remarkable rapidity. It is well to remember that a rounded, soft mass presenting against the rectum may

1. Maingot, R.: *Abdominal Operations.* Appleton-Century-Crofts, New York, 1948. Pp. 761 and 762.

2. Deaver, J. M. and Martin, A. G.: *Cyclopedia of Medicine, Surgery and Specialties;* Vol. I. pp. 732-733. F. A. Davis Co., Philadelphia, 1950.

3. Gross, R. E.: *The Surgery of Infancy and Childhood.* Saunders, Philadelphia, 1953. Pp. 274 through 277.

prove to be a loop of intestine which is stuck in the pelvis. The surgeon should be confident in the nature of any mass before plunging a knife into it. In a child it is almost always better to drain a pelvic abscess by a trans-abdominal route."

Gross[3] also reports that in a seven-year period between 1944 and 1951, he had 28 cases of pelvic abscess in 372 cases of ruptured appendicitis. In only 5 of these cases was secondary operation for drainage necessary.

In children, there is a high incidence of rupture of the organ with peritonitis before the time of surgery for acute appendicitis. In Gross' series, 345 out of 729 or 47 per cent of cases had rupture of the organ with localized abscess or a diffuse peritonitis at the time of surgery. During the past three years, I have had 10 cases of ruptured appendicitis with peritonitis out of 40 appendectomies in children of under 10 years of age. This is an incidence of 25 per cent

THERE are several reasons for this high incidence of ruptured appendicitis in childhood. (1) The small size of the abdomen of a child containing an inflamed organ will often cause generalized tenderness, since the entire abdominal area of a child could usually be superimposed on the right lower quadrant of an adult. In a child, this makes early diagnosis by apparent localization of the disease difficult. (2) The relative "immaturity" of the omentum of a child makes it a less dependable aid in localizing the infection. (3) The thinness of the wall of the appendix of a child makes for early rupture, and (4) there is often a concomitant respiratory infection in children with the associated generalized lymphoid hyperplasia also occurring in the appendix. This often initiates acute appendicitis and may make one overlook the early signs of disease by attributing abdominal symptoms to the upper respiratory infection.

During the past three months, I have had two cases of pelvic abscess following ruptured appendicitis, the only two in the series of ten ruptured appendices in the past three years.

CASE ONE

A 5-year old girl was admitted to Babies' Hospital in Newark with a three-day history of abdominal pain, fever, and vomiting. Temperature on admission was 104.6 degrees, white blood count 20,900 with 80 per cent neutrophiles. The abdomen was slightly distended with generalized tenderness and the child moderately dehydrated. Intravenous fluids were started in the admitting room and the child taken directly to surgery. Operation through a McBurney incision revealed a gangrenous appendix with a large amount of free pus in the abdomen. Appendectomy was carried out and Penrose drains were placed in the right lateral gutter and in the pelvis and brought out through the center of the incision. Culture of the peritoneal pus revealed E. Coli. Postoperatively the child was placed on intravenous fluids, Chloromycetin® and Combiotic® parenterally. Oral feedings were started on the second postoperative day and the child's condition seemed quite good. Temperature came down and ranged between 99.6 degrees and 101 degrees during the first 5 days postoperatively. The drains were removed on the 5th postoperative day. On the sixth day the temperature rose to 103 degrees and the child again complained of abdominal pain more in the left lower quadrant. The abdomen appeared slightly distended but the child tolerated oral feedings well and the bowels, though slightly loose, moved adequately. Rectal examination revealed slight induration anterior to the rectum. The fever and abdominal pain continued and the rectal mass became more and more evident and more and more fluctuant until the 11th postoperative day when the child suddenly had several profuse and extremely foul smelling stools. The pelvic mass disappeared. The temperature immediately fell to normal and she made a very speedy and uneventful convalescence.

CASE TWO

An eight-year old boy was admitted to Babies' Hospital in Newark with a 2-day history of abdominal pain, fever, and vomiting. Temperature on admission was 100.8 degrees. There was generalized abdominal tenderness, more marked in the right lower quadrant. Bowel sounds were diminished. There was marked rectal tenderness bilaterally, the white blood count was 18,000 with 78 per cent neutrophiles. Operation was carried out shortly after admission and a ruptured, gangrenous appendix with free pus in the abdomen was found. Appendectomy was done and drains were placed in the pelvis and in the right lateral gutter and brought out through the central portion of the incision. A culture of the pus taken at operation was reported as showing no growth. However, a culture taken from the peritoneal drainage on the 4th day revealed Staphylococcus aureus resistant to all drugs except polymyxin B.

The child was placed on intravenous fluids and Chloromycetin® and seemed to do well for the first 5 days. On the 4th day the drain was removed.

On the 5th day the child developed a temperature of 104 degrees and complained of abdominal pain, especially in the left lower quadrant. Rectal examination revealed induration anterior to the rectum. The child continued to run a febrile course but was able to take oral feedings and had adequate bowel movement until the 12th postoperative day, when the child had about 8 or 10 watery bowel movements consisting almost entirely of gray pus. The rectal mass subsided quickly as did the fever and the child made a very speedy convalescence.

In both these cases, as the pelvic abscesses were enlarging and becoming more fluctuant, I was tempted several times to institute surgical drainage, either abdominally, as recommended by Gross,[3] or rectally. But the children were both taking a fairly adequate diet. There were no signs of intestinal obstruction. The infection was well localized. For these reasons, I felt that nothing would be lost by waiting. In children the rectal wall is much thinner than in adults. An abscess will, therefore, more easily erode through it and thereby drain safely and spontaneously. The reverse has been my experience with adults where surgical drainage must nearly always be done.

CONCLUSIONS

1. Pelvic abscess especially in children following peritoneal soilage will probably increase in frequency as more and more resistant strains of bacteria develop.

2. Conservative therapy is warranted for 7 to 10 days after the recognition of the complication of pelvic abscess, unless there are signs of intestinal obstruction. This is especially true in children since spontaneous drainage will often occur.

364 Ridgewood Avenue

Constipation Can Be Fatal

Vascular thrombosis leading to sudden death may result from excessive straining at stool by constipated individuals.

A team of researchers from Kings County Hospital, Brooklyn, reported a survey of this in the April 1959 issue of the American Journal of the Medical Sciences. They state that the reduction of straining effort is essential if these episodes are to be avoided.

This may be accomplished by the administration of an appropriate constipation corrective.

On the basis of hundreds of patient observations, they noted that some of the changes caused by straining are of sufficient intensity and duration to bring on an automatic cycle of extreme variations in peripheral blood pressure and blood flow—known as the Valsalva maneuver. This phenomenon occurs during straining when the pressure in the chest cavity is forcibly raised to 40 millimeters of mercury and sustained for ten seconds. Under these conditions, there results a series of reflex circulatory changes including sharply rising and falling arterial and venous blood pressures.

The study which directly measured the changes in venous pressure and the arterial circulation in the extremities during actual bowel function of normal and constipated males and females showed that straining initiated marked elevations. These changes further increased with the severity of the straining.

The venous pressure increased dramatically during the strain period, as high as 50 millimeters over the resting period and abruptly dropped to the base level with the sudden release of the strain. This action, they cautioned, "can cause a suction action capable of detaching a bland thrombus and could cause sudden death if the blood clot became lodged in the lungs or heart." They further warned, "that 50 per cent of all normal adults of middle age or over harbor silent, detachable clots in the veins of their feet or calves."

Trustees' Meeting

May 17, 1959

At its May 17 session, the Board reviewed the following with reference to health care of the aged:

a. The January 18, 1959, action of the Board in which it recorded approval and support of the A.M.A. recommendations on special health insurance coverage for people over 65 years of age with modest resources and reduced incomes; and four recommendations thereon. This report was presented to the House of Delegates.
b. The action of the House of Delegates which referred the report back to the Board of Trustees for further study with power to act; and the objections of Reference Committee "C."
c. A report from Medical-Surgical Plan on the development of a contract for prepaid medical and surgical coverage for persons over 65 years of age. This was approved, the phrase "reduced income" being defined at $2000 for single persons and $3000 a year for couples.
d. A resolution from the Union County Medical Society. In light of the above actions, this was laid on the table.

It was determined that these actions be referred to the Special *ad hoc* Committee on Medical Care Plans and Coverage to effect a reduction in premium if possible. The Board further voted to reaffirm its previous action of January 18, 1959, with regard to hospital coverage for the group over age 65. It was also agreed that it be suggested to the New Jersey Hospital Association that it cooperate with The Medical Society of New Jersey, and with the Blue Shield and Blue Cross Plans, in offering the services of the hospitals in this State at reduced rates to those over 65 with limited means.

With respect to resolutions on social security for physicians (adopted by the 1959 House of Delegates) the Board voted to instruct the New Jersey delegates to the American Medical Association to introduce a resolution in favor of social security for physicians at the AMA annual meeting this year. With the permission of the Board, the chairman directed that the A.M.A. be informed of the results obtained by the canvasses made by the component societies and reported to the House of Delegates; the adoption of resolutions by the 1959 House of Delegates; and today's action of the Board.

The Board reviewed previous action in which it had approved the amendment of the Medical Practice Act to include medical or x-ray technicians in the exemption provision of the Act, together with the report of the reference committee, and the action of the House of Delegates which referred the matter back to the Board for further study. This was recomitted to the Council on Legislation.

The resolution of the House of Delegates on hypnosis was reviewed. This called for a committee to study the problem of "entertainment hypnosis" and whether its practice should be prohibited by law in New Jersey. This was referred to the Council on Medical Service for study and report with the suggestion that the Council confer with the Chairman of the Special Committee on Mental Health.

A resolution was adopted by the House of Delegates which called for an investigation of the possibility of a withholding premium that would enable a subscriber to obtain a paid-up Blue Cross-Blue Shield policy upon retirement. This item was referred to Hospital Service Plan and Medical-Surgical Plan for study and reply.

The Board reviewed its previous action, to the effect that it would *not* attempt to repeal the amendment to the 1953 Enabling Act. This concerned MSP payments to chiropodists. The Board voted to refer this to the Council on Legislation for further study and report.

The Board next considered the matter of accreditation of hospitals and intern and resident training programs. Last fall the Board had approved the Maryland resolution on this. In view of contrary action taken by the House of Delegates, however, the Board instructed our Delegates not to support the Maryland resolution, as written, but to use their own discretion with reference to supporting its objectives.

The House of Delegates had adopted the supplemental report on radiologic hazards of the Committee on Cancer Control including the recommendation that the report be made available to all practicing physicians in New Jersey. The Board directed that the report be published in an early issue of THE JOURNAL, in fulfillment of this recommendation.

A resolution from Essex County, adopted

y the House of Delegates, recommended that teps be taken to end the fitting of contact enses and use of drugs by non-medical personnel. The Board directed the matter be rought to the attention of the State Board of Medical Examiners.

The Cumberland County resolution on the se of drugs by optometrists, adopted by the House of Delegates, was reviewed. It was directed that this be brought to the attention of he State Board of Medical Examiners.

The resolution calling for the compilation nd publication of a directory of rehabilitation ervices in New Jersey—as adopted by the House of Delegates—was reviewed. It was hen referred to the Special Committee on Rehabilitation "to take such steps as may be necessary to develop this project with all expediency" and without cost to The Medical Society of New Jersey.

The following resolution, adopted by the House of Delegates of the A.M.A. at the Minneapolis meeting, December 1958, was held over by the Board from its meeting on April 12, 1959, pending action by the House of Delegates on the revision of the Bylaws:

> Resolved, that the House of Delegates of the American Medical Association urge all component societies to make every effort to provide a type of membership for Armed Forces, Public Health Service, and Veterans Administration physicians which will enable them to become Active Members of constituent societies and of the A.M.A.

Two of the requirements for membership in The Medical Society of New Jersey, as adopted by the House of Delegates, are:

Chapter XI, Section 2:

> "be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners; and
>
> "be legally registered under that license in a county of New Jersey;"

The Board agreed that while it was sympathetic to the purpose of the resolution it could take no action.

Mr. Nevin pointed out that the A.M.A. has urged that paramedical groups be retained as instrumentalities of the medical profession and not be separately licensed as separate professional entities. The Society of Medical Technologists is the only organization in the medical laboratory field recognized by the A.M.A. and the American Hospital Association. Their objectives are worthy. Question arises only on their request for official liaison between their organization and the Medical Society. It has been the policy of the Society to limit official liaison with the allied professions, but it was questioned that it is necessary or desirable that the Society's liaison representatives (President, President-Elect, Immediate Past-President, and Executive Officer) form a joint committee with paramedical groups.

Dr. Bowers stressed the importance of maintaining contact with all paramedical groups. To effect this he expressed the opinion that a member or members of the Council on Public Health, as assigned by its chairman, could serve as official intermediaries to lay health organizations and paramedical groups with the understanding that such assignments do not imply endorsement of the organization or group or its program. Such intermediaries would serve as the official contact between the organization or group and The Medical Society of New Jersey.

The Board of Trustees concurred in the President's opinion. The matter was referred back to the Council on Public Health with an expression of the Board's concurrence in the President's opinion.

The functions and responsibilities of all committees terminated with the adoption of the new Constitution and Bylaws. The Bylaws, Chapter IX, Section 19 provides:

> (a) Special committees may be created by the House of Delegates or by the Board of Trustees.
> (b) They shall be appointed by the President or the Chairman of the Board of Trustees.
> (c) Their specific functions and duration shall be clearly defined.

Dr. Bowers requested authorization for the appointment of the following special committees to continue the programs and assignments of the previous committees:

Special Committees to the Council on Public Health:

a. Cancer Control
b. Child Health
c. Chronically Ill and Aging
d. Conservation of Hearing and Speech
e. Conservation of Vision
f. Maternal and Infant Welfare
g. Mental Health
h. Rehabilitation

Special Committees to the Council on Medical Services:

a. Industrial Health
b. Workmen's Compensation

Special Committees of the Society:

a. Civil Defense-Disaster Control
b. Physicians Placement Service
c. Traffic Safety

The Board authorized the appointment of the special committees listed.

Dr. Bowers presented the following statement of Method of Operation for special committees and requested the Board's approval:

Special Committees are established for intra-Society function.

They are intended to serve the Society by studying and making recommendations concerning particular matters referred to them, or officially approved for their consideration; and by carrying out approved programs.

They are not empowered to deal directly with agencies or representatives of agencies outside The Medical Society of New Jersey except by specific permission or assignment of the Board of Trustees.

They may not commit the Society in any regard.

They are to report the results of their studies and to submit their recommendations only to the Board of Trustees or to the Administrative Council of proper jurisdiction.

They are free to call upon other committees of the Society for assistance or information in the furtherance of their investigations and studies.

They are likewise free to solicit information and assistance from specialty societies through the official intermediaries to specialty societies designated by the Board of Trustees.

If uncertainty as to procedure develops, the chairmen of special committees should consult the Executive Officer for clarification.

Upon motion made, seconded and carried the "Method of Procedure for Special Committees" was approved.

Dr. Schretzmann read his Treasurer's report. He stated that in accord with the authorization of the Board, $100,000 of the Society's funds is being invested in 90-day treasury bills which will pay 2.9 per cent interest.

Upon motion by Dr. Sharp—seconded by Dr. Greifinger, and carried—the report of the Treasurer was accepted.

Dr. Wegryn, Dr. Eckstein, and the Executive Officer had attended the public hearing held by the Administration of Public Medical Care Study Commission on May 7. It became evident in the early part of the hearing that each organization represented was prepared with a statement, and the chairman, Mrs. Yaguda, was looking to the Society's representatives for a statement from The Medical Society of New Jersey. Therefore, the following statement was read into the record of the hearing by the Executive Officer.

The Medical Society of New Jersey, through its designated representatives, has conferred with the Commission in a cooperative effort to assist it in the realization of the purposes for which it was established.

The members of The Medical Society of New Jersey—now as always—are dedicated to supplying to the people of this State adequate necessary medical and surgical care.

The fundamental policy of The Medical Society of New Jersey—now as always—is that necessary medical care must not, and shall not, be denied to any individual because of his inability to pay for the services rendered.

Therefore it applauds the efforts of the representatives of government to evolve a program which will, on an equitable basis, underwrite those costs for medical care which the responsible individual citizen cannot himself meet. To this end The Medical Society of New Jersey has offered and will continue to offer, full cooperation in the endeavor accurately to appreciate and efficiently to deal with the medical care needs of the indigent and the medically indigent of New Jersey.

On motion made, seconded and carried, this report was adopted.

The President announced the appointment of the following liaison representatives and special committees:

1. A.M.E.F., New Jersey Chairman
   Dr. Luke A. Mulligan, Leonia
2. Audit Committee
   Dr. Ralph M. L. Buchanan, Chairman, Phillipsburg
   Dr. Joseph R. Jehl, Clifton
   Dr. Carl M. Ware, Shiloh
3. Blood Bank Commission of New Jersey
   Authorized agent of Medical Society in approved Blood Bank Programs
4. Blood Bank Commission of New Jersey, Representatives on
   Dr. William T. Read, Jr., Camden
   Dr. Kenneth E. Gardner, Bloomfield
5. Cardio-Pulmonary Function Laboratory, General Advisory Committee to
   Dr. Philip J. Kunderman, New Brunswick
6. Chronic Illness, State Council on (appointed by Governor)
   Dr. William H. Hahn, Newark
7. Civil Defense Organization, State
   Dr. R. Winfield Betts, Medford
8. Council for Local Public Health Services, Executive Committee
   Dr. Louis S. Wegryn, Elizabeth
9. Crippled Children and Adults, Medical Advisory Committee to New Jersey Chapter, National Society of
   Dr. Henry Briggs, East Orange
   Dr. Lewis H. Loeser, Newark
   Dr. Harrold A. Murray, Sea Girt
   Dr. John G. Novak, Newark
   Dr. Sol Parent, Newark
10. Crippled Children Commission, State
    Dr. Frederick G. Dilger, Hackensack (term expires 1961)

11. Disaster Control, Joint Committee with Hospital Association
Members of Special Committee on Civil Defense-Disaster Control

12. Education Department, Liaison with State Department
Dr. Robert E. Jennings, South Orange

13. Employ the Physically Handicapped, Governor's New Jersey Committee to
President (Dr. F. Clyde Bowers, Mendham)

14. Epilepsy Project, New Jersey Consultation Service for Convulsive Disorders
Dr. Harrison F. English, Trenton

15. Epileptics, Advisory Panel to Motor Vehicle Director on
Dr. Harrison F. English, Trenton

16. Eye Health Screening Program, 1959
Dr. Arthur E. Sherman, East Orange

17. Fluoridation, Joint Committee on (State Department of Health and New Jersey Dental Society)
Dr. Charles H. Calvin, Perth Amboy
Dr. Louis S. Wegryn, Elizabeth

18. Health Department, Liaison with State
Dr. Elmer J. Elias, Trenton

19. Health Insurance Conference
Dr. Daniel F. Featherston, Asbury Park
Dr. J. Wallace Hurff, Newark
Dr. Royal A. Schaaf, Califon
Dr. Marcus H. Greifinger, Newark
Dr. Rudolph C. Schretzmann, Bergenfield
Dr. Ralph M. L. Buchanan, Phillipsburg
Dr. Louis S. Wegryn, Elizabeth
Mr. Richard I. Nevin, Trenton
(8 representatives of Health Insurance Council)

20. Health and Sanitary Association, New Jersey —Health Careers Project Committee
Delegate—Dr. Louis S. Wegryn, Elizabeth
Alternate—Mr. Richard I. Nevin, Trenton

21. Historian-Archivist
Dr. Fred B. Rogers, Trenton

22. Hospital Advisory Council, State Department of Institutions and Agencies (appointed by Commissioner)
Dr. C. Byron Blaisdell, Asbury Park (term expires 12/31/60)
Dr. Luke A. Mulligan, Leonia (term expires 12/31/61)

23. Hospital Service Plan Board of Trustees
President (Dr. F. Clyde Bowers, Mendham)
(H.S.P. Bylaws provide that President serve on Board during his term of office)

24. Hospital Service Plan Liaison Committee
21 County Advisory Committees to M.S.P.

25. House Maintenance, Staff Policies, and Personnel Relations, Special Committee on
President (Dr. F. Clyde Bowers, Mendham)
President-Elect (Dr. Jesse McCall, Newton)
Chairman, Board of Trustees (Dr. Luke A. Mulligan, Leonia)
Chairman, Finance and Budget Committee (Dr. David B. Allman, Atlantic City)
Chairman, Former House Committee (Dr. L. Samuel Sica, Trenton)
Secretary (Dr. Marcus H. Greifinger, Newark)
Treasurer (Dr. Rudolph C. Schretzmann, Bergenfield)
Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)
Administrative Secretary, Ex-Officio (Mrs. Edith L. Madden, Trenton)

26. Lay Health Organizations and Paramedical Groups, Official Intermediaries
(assignment of official intermediaries from The Medical Society of New Jersey to lay health organizations and/or paramedical groups does not imply endorsement of the organization or group or its program)
Members of the Council on Public Health, as assigned by the Chairman

27. Legislative Keymen, National
Dr. C. Byron Blaisdell, Asbury Park
Dr. Levi M. Walker, Atlantic City (Deputy)

28. Liability Insurance Study Committee
Dr. Marcus H. Greifinger, Chairman, Newark
Dr. Jerome G. Kaufman, Newark
Dr. Joseph P. Donnelly, Jersey City
Dr. Elton W. Lance, Rahway
Dr. Daniel F. Featherston, Asbury Park
Dr. John J. Bedrick, Bayonne
Dr. David B. Allman, Consultant, Atlantic City

29. Medical Care Plans and Coverage, Ad Hoc Committee on
President (Dr. F. Clyde Bowers, Mendham), Chairman
President-Elect (Dr. Jesse McCall, Newton)
1st Vice-President (Dr. Ralph M. L. Buchanan, Phillipsburg)
Executive Officer (Mr. Richard I. Nevin, Trenton)
2 Board Members, Medical-Surgical Plan of New Jersey
Dr. Joseph P. Donnelly, Jersey City
Dr. Rudolph C. Schretzmann, Bergenfield
Immediate Past-President (Kenneth E. Gardner, Bloomfield), Consultant

30. Medical Care Plans, Stand-by Committee on State (Institutions and Agencies)
Dr. Charles H. Calvin, Perth Amboy
Dr. Irving Klompus, Bound Brook
Dr. David Eckstein, Trenton
Dr. John B. Fuhrmann, Flemington

31. Medical-Legal Testimony, Special Committee on
Dr. Marcus H. Greifinger, Chairman, Newark
Dr. Joseph P. Donnelly, Jersey City
Dr. Jesse McCall, Newton
Dr. Ralph M. L. Buchanan, Phillipsburg
Dr. Daniel F. Featherston, Advisor, Asbury Park
Dr. F. Clyde Bowers, Ex-Officio, Mendham

32. Medical Liaison Committees—Dental, Legal, Hospital, Nursing, and Pharmaceutical (where number of representatives from other organizations is larger than number of Medical Society representatives, the latter number to be increased from the Presidential Officers to equal the former number)
President (Dr. F. Clyde Bowers, Mendham)
President-Elect (Dr. Jesse McCall, Newton)
Immediate Past-President (Dr. Kenneth E. Gardner, Bloomfield)
Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)

33. Medical-Nursing-Hospital Conference (Tri-Partite Conference)
President (Dr. F. Clyde Bowers, Mendham)
President-Elect (Dr. Jesse McCall, Newton)
Immediate Past-President (Dr. Kenneth E. Gardner, Bloomfield)
Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)

34. Medical-Surgical Plan Liaison Committee
6 Officers of The Medical Society of New Jersey
21 County Chairmen of Advisory Committees to M.S.P.

35. Medicare Fiscal Agent
Medical Service Administration of New Jersey

36. Medicare Program, Special Committee on
Dr. Jesse McCall, Chairman, Newton
Dr. Joseph R. Jehl, Clifton
Dr. Carl N. Ware, Shiloh
Dr. L. Samuel Sica, Trenton

37. Mental Health, State Commission on
Dr. Richard E. Gordon, Englewood (Commission established by Legislation)

38. National Foundation, New Jersey Scholarship Committee
Dr. F. Clyde Bowers, Mendham

39. Nurses' Program on CD-DC, Steering Committee for
Dr. R. Winfield Betts, Medford

40. Nutrition Council, New Jersey
Dr. S. William Kalb, Newark

41. Pension Plan, Special Committee on
Chairman, Finance and Budget Committee (Dr. David B. Allman, Atlantic City)
Treasurer (Dr. Rudolph C. Schretzmann, Bergenfield)
Chairman, Special Committee on Staff Policies, etc. (Dr. F. Clyde Bowers, Mendham)

42. Permanent Committee on Blue Shield and Blue Cross Plans of New Jersey
Chairman, Board of Trustees (Dr. Luke A. Mulligan, Leonia)
President (Dr. F. Clyde Bowers, Mendham)
Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)
(2 representatives from M.S.P.)
(2 representatives from H.S.P.)

43. Principles of Approach to Specialty Services Conference Group
Presidential Officers
Dr. F. Clyde Bowers, Mendham
Dr. Jesse McCall, Newton
Dr. Ralph M. L. Buchanan, Phillipsburg
Dr. Louis S. Wegryn, Elizabeth
Chairman, Board of Trustees
Dr. Luke A. Mulligan
Hospital Service Plan (3 representatives)
Medical-Surgical Plan (3 representatives)
New Jersey Hospital Association (3 representatives)
Radiological Society of New Jersey (3 representatives)
New Jersey Society of Pathologists (3 representatives)

44. Public Medical Care, State Commission to Study
Dr. Frank J. Hughes, Camden (appointed by Governor)

45. Retirement Plan for Physicians, Investigating Committee on
Dr. Jerome G. Kaufman, Chairman, Newark
Dr. John J. Bedrick, Bayonne
Dr. Albert F. Moriconi, Trenton
Dr. Morton F. Trippe, Asbury Park
Dr. Nicholas E. Marchione, Vineland

46. Safety Council, New Jersey State
Executive Officer (Mr. Richard I. Nevin, Trenton—President's representative)
(Council Bylaws provide Board membership for President of The Medical Society of New Jersey)

47. Seton Hall Academic Society (Chapter of Student AMA), Representative on Advisory Committee to
Dr. Kenneth E. Gardner, Bloomfield

48. Welfare Council, New Jersey
Medical Care Committee
Chairman, Council on Medical Services (Dr. Irving Klompus, Bound Brook)

49. Widows and Orphans of Medical Men of New Jersey, Liaison Representative with the Society for the Relief of
Dr. Kenneth E. Gardner, Bloomfield

50. Workmen's Compensation and State Employees, Special Committee on
Dr. Marcus H. Greifinger, Chairman, Newark
Dr. Andrew C. Ruoff, III, Pompton Plains
Dr. Carl N. Ware, Shiloh

EXECUTIVE COMMITTEE (Chapter IV, Section 5 (b)):

President (Dr. F. Clyde Bowers, Mendham)
President-Elect (Dr. Jesse McCall, Newton)
1st Vice-President (Dr. Ralph M. L. Buchanan, Phillipsburg)
2nd Vice-President (Dr. Louis S. Wegryn, Elizabeth)
Chairman, Board of Trustees (Dr. Luke A. Mulligan, Leonia)

The renewal contract submitted by the Defense Department's Office for Dependents' Medical Care for 1959-60 was reviewed by the Society's fiscal agent—Medical Service Administration—in its entirety. Each of the changes was considered proper and satisfactory. MSA recommended execution of the contract by the Society.

Upon motion, the Board authorized that the designated officers sign the contract for 1959-60.

A communication was read from the Medical Society of Wisconsin requesting our support for an AMA resolution calling for the development of a commemorative postage stamp on safe transportation, and a further request that a supporting resolution be introduced into the New Jersey Legislature. The letter was referred to the A.M.A. Delegates with action left to their discretion.

The Division of Chronic Illness Control, New Jersey State Department of Health, is

conducting, in cooperation with the New Jersey Neuropsychiatric Institute, a symposium at the Institute next month. Co-sponsorship by the Society was requested, as well as permission to include the Society's name in the program as such.

Following review of the program outline, co-sponsorship by the Society was approved.

A member-ophthalmologist reported the disapproval by the New Jersey Academy of Ophthalmology and Otolaryngology of the recommendations of the Society's Special Committee on the Conservation of Vision. This had approved, in principle, the development of an ophthalmologic plan to make available the services of diagnostic and initial treatment by physicians to members of unions interested on a funded prefinanced basis, and the development of a pilot project. The communication stated that the Academy had voted down a similar plan last year. The letter requested a review of the report.

The matter was thoroughly discussed and it was decided to explain to the Academy how the Board studies such matters and why this decision was taken.

Our Life Insurance Quota

On July 1 over 30 per cent of the Essex County membership had applied for The Medical Society of New Jersey Life Insurance Program (see full page advertisement on the inside front cover of this issue). As a result, coverage was issued to Essex County's impaired applicants, whose policies had been held in suspense pending the achievement of the quota.

It is also possible for other large counties including Bergen, Camden, Hudson, Morris Passaic, Union, Middlesex, Mercer, and Monmouth to achieve their 30 per cent quotas for issuance of policies to their impaired risks.

In early July, when this article was written, Middlesex needed only four applications for its qualification; Morris County needed but six, and Hudson County needed only 34.

Nearly four-fifths of the over-all state-wide quota of 30 per cent has been passed and over eleven million dollars of insurance is in force for our members under this plan as this article goes to press.

Members of the state society who are in active practice and under the age of sixty-five are eligible to apply for this fine program. Upon attainment of the 30 per cent state (or eligible county) quota, policies will be issued to all in this category who apply without regard to insurability. We urge that those members who have not yet applied send in their applications at once so that they can be counted (acceptable risks as well as those with impairments) toward the over-all quota of the state and of their county.

J. Wallace Hurff, M.D., *Chairman*
Committee on Medical Defense and Insurance

Fellowships in Rheumatology

Several interesting fellowships and investigator awards are available this year from the Arthritis and Rheumatism Foundation. Stipends range from $1500 to $10,000 a year. For details, write to Medical Director, Arthritis and Rheumatism Foundation at 10 Columbus Circle, New York 19, New York.

Fellowships in Neuro-Muscular Disease

Fellowships are now available for either basic or clinical work in the field of neuromuscular diseases. The stipend varies from $5,000 to $7,000 a year. For details write to the Medical Director at the Sister Kenny Foundation, 2400 Foshay Tower, Minneapolis 2, Minnesota.

Announcements • • •

Courses at Montefiore

Montefiore Hospital in the Bronx announces courses, under the aegis of Columbia University, in dermatology, cardiology, peripheral vascular disorders, cardiac surgery, allergy, hematology, phthisiology, gastroenterology, teratology, ophthalmoscopy, neurology, and oncology. More details may be obtained from the Secretary of Instruction, Montefiore Hospital, Bainbridge Avenue and 210 Street, New York 67, N. Y.

A.C.S. Meets in Atlantic City

Under a local committee on arrangements, chaired by Dr. Stuart Z. Hawkes, the American College of Surgeons meets in Atlantic City, September 28 through October 2. Included in the program are nine graduate courses and panel discussions, symposia, research reports, papers, moving picture clinics, and exhibits. Major addresses will be delivered by Dr. Dean Rusk (president of Rockefeller Foundation), Dr. Owen Wangensteen, and Dr. David Paton Cuthbertson. Dr. Cuthbertson will be coming from Scotland to discuss parenteral fluid therapy. More details may be obtained from Dr. Paul R. Hawley at 40 East Erie Street, Chicago 11, Illinois.

Obstetricians-Gynecologists to Meet in September

September 24, 25 and 26 are the dates and the Waldorf-Astoria in New York is the place for a meeting of the Second District of the American College of Obstetricians and Gynecologists. A busy and productive program has been developed. Details may be secured from Dr. A. C. Posner at 51 East 90 Street, New York 28, N. Y.

Psychiatric Research Meeting

New York's Waldorf-Astoria will be th scene, October 23-25 of the fourth annual mee ing of the Eastern Psychiatric Research As sociation. The program includes a discussio of space medicine, chemotherapy, indemnifica tion agreements in research, disarrange chromosome anatomy and the genetics of be havior. Obtain full details from Dr. David Impastato at 40 Fifth Avenue, New Yor N. Y.

Psychosomatic Convention

The American Academy of Psychosomatic will meet in Cleveland, Ohio, October 15, 1 and 17. Topics include office management o psychosomatic problems. Many of the paper and seminars will interest nurses and socia workers. Obtain more information from Dr Bertram Moss at 55 East Washington Street Chicago 2, Illinois.

Jerseyites Elected at Chest Physicians Meeting

At the June 7 session of the American Col lege of Chest Physicians, the following New Jersey doctors received the indicated accolades

Dr. Irving Willner, Newark, was electe Vice-Chairman of the Board of Regents of th College. Dr. A. A. Carabelli, Trenton, becam Governor for New Jersey. The following phy sicians from New Jersey received their certi ficates of Fellowship in the College: David T DuBow, Plainfield; Janet Geraghty-Deutsch Jersey City; Rubin Grossman, Bayonne; Jo seph M. Lally, Jersey City; Leon Martin, New Brunswick; Elmer N. Mattioli, Vineland; Al bert Minzter, Elizabeth; James J. Nobile, Ho boken; Vincent Pidoto, Metuchen; George F Piltz, Guttenberg; N. Maurice Re, Palis ade; Herbert J. Rosen, Dover; Alfred E. Ro senthal, Bayonne; Harold L. Scales, Teaneck Allan R. Shuster, Atlantic City; Alfred Yager North Bergen.

Goiter Conference in London

An International Goiter Conference will be held July 5 to 9, 1960, in London, England, under the auspices of the American Goiter Association. The Association will make available to worthy candidates a limited number of travel grants. Application forms for this are available from John C. McClintock, M.D., 151 Washington Avenue, Albany 10, New York. *Deadline for applications*: Dec. 31, 1959.

New Local Psychoanalytic Society

On June 13, 1959, a New Jersey Psychoanalytic Society was formed. It has been accepted as an affiliate of the American (and International) Psychoanalytic Association. Its first president is Herman Shlionsky of Montclair. The vice-president is Raymond H. Gehl of Newark and its first secretary is John E. Hughes of East Orange. The new society meets regularly at the Academy of Medicine in Bloomfield. Further details may be obtained from Dr. John E. Hughes at 377 South Harrison Street in East Orange.

Air Ambulance Service

Announcement is made of airplane ambulance facilities to and from Newark Airport. Ambulances may be driven directly to the landing strip and patients littered on to ambulance planes. Oxygen is available en route. Charter air ambulance service is available 24 hours a day. For details, telephone Newark Air Service at MArket 2-5128. Mailing address is Hangar 12, Newark Airport, Newark, N. J.

Attention: All Office Nurses!

A new organization of nurses serving in physicians' offices has been announced. This is headquartered at 1317 F Street, N. W., Washington 4, D.C. Interested physicians' nurses may obtain details by writing to the American Association of Doctors' Nurses at the Washington address.

Surgeons Go Back to Old Virginny

Surgeons who want to get away from it all are invited to visit Hot Springs, Va., November 16, 17, 18 for a surgical seminar under the auspices of the International College of Surgeons. For details, write to Dr. E. G. Gill, 711 South Jefferson St., Roanoke, Va.

Cancer Chemotherapy Conference

The Armistice Day week-end has been scheduled for a conference on cancer chemotherapy under the aegis of the U. S. Public Health Service. The meeting will be at the Statler in Washington, D. C. For details, write to Dr. B. H. Morrison, National Cancer Institute, Bethesda 14, Maryland.

"Detail Men" Are Puppeteers Too

The New Jersey Medical Sales Representatives Association, Inc. gave a puppet show at the banquet honoring President and Mrs. Kenneth E. Gardner at our Annual Meeting in Atlantic City, in May.

They have sponsored and operated puppet shows for pediatric patients at St. Mary's Hospital in Hoboken and Holy Name Hospital in Teaneck.

Corresponding Secretary of the Association is Mr. Richard H. Adler, 2512 Cottage Ave., North Bergen, N. J. Hospital and other groups wishing this entertainment for worthy charitable purposes should communicate with Mr. Adler.

Health Insurance Bibliography

You may obtain, gratis, a unique 25-page pamphlet listing books and journals on health insurance. Also included is a roster of nationwide organizations having relationship to the task of financing medical care. The booklet covers special fields, too, like gerontology and social security. To obtain a copy, write to the Health Insurance Institute at 488 Madison Avenue, New York 22. Ask for "List of Worthwile Health Insurance Books."

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held on April 10 at the Children's Seashore House. The president, Dr. S. Eugene Dalton, opened the scientific meeting by introducing Dr. Paul Steel, who, in turn, introduced his brother Dr. Howard Steel, Assistant Professor of Orthopedic Surgery at Temple University School of Medicine. His subject was "Staphylococcal Infections and Their Complications." The papers were discussed by Drs. Naame, Merendino, Johnson, Stamps, Allman, and Kaman.

The minutes of the March meeting as published in the April issue of the Bulletin were approved. The minutes of the Executive Committee meeting held April 9 were read and approved.

Dr. Southard reported for the Public Health Committee. This committee suggested that children be immunized according to the latest recommendations of the American Academy of Pediatrics, which advised three injections, one month apart, followed by a fourth after seven months and a fifth injection after twelve months. Dr. Salasin then discussed a health survey proposed by the State Public Health Department. Dr. Salasin presented his objections to this technic and made other suggestions. Dr. Salasin also thought that it would be unnecessary because the school boards were in better position to carry out such a survey.

Dr. Southard also recommended that the school districts require immunization of children before registration at schools.

A resolution was then passed putting the Society on record as recommending that school districts make poliomyelitis immunization a requirement for admission to school.

Also passed was a program developed by the Public Relations Committee setting up a medical student loan fund.

Dr. Gleason reported for the Insurance Committee that 59 members had given affirmative replies regarding possible group participation in the Medical-Surgical Plan of New Jersey. In spite of the publicity, there apparently are too few doctors interested to form a group.

Dr. Brunt reported for the State Department of Institutions and Agencies. He brought out the necessity of cooperation of the community to raise enough money to continue the Guidance Center. We can cooperate by making donations and informing the community of the need for the Guidance Center.

Dr. Gross reported for the Tuberculosis Committee and stated that there would be a survey on May 11 in Atlantic City. This would be limited but he urged all doctors to cooperate in sending patients for chest x-rays.

LEONARD B. ERBER, M.D.

Reporter

Middlesex

The annual dinner meeting of the *Middlesex County Medical Society* was held at The Pine Metuchen, at 6:30 p.m., June 17.

At the conclusion of the dinner, Dr. George J. Kohut, the retiring president, called the business meeting to order.

On recommendation of the Judicial Medical Ethics Committee, Dr. B. F. Slobodien, Chairman, Dr. Henry Keen Shoemaker, New Brunswick, was elected to Regular membership from two years of Associate membership. Dr. Roger J. Madiou of New Brunswick and Dr. Joseph Uhrik of Metuchen were elected to a two-year period of Associate membership.

Dr. B. F. Slobodien, Chairman of the Medical Liability and Insurance Committee, reported that we needed seven more members to sign up for the new life insurance policy in order to reach our quota to obtain this coverage.

Dr. Charles H. Calvin, Chairman of the Nominating Committee presented the following panel of officers for 1959-60. They were unanimously elected.

President—John A. Smith, South River

Vice-President—Stanley A. Gadek, Perth Amboy

Secretary—John S. Van Mater, New Brunswick

Treasurer—Reuben Levinson, Perth Amboy

Reporter—Thomas I. Steinberg, Metuchen.

Board of Trustees—George J. Kohut, Chairman, Sidney D. Becker, Charles H. Calvin, Malcolm M. Dunham, B. F. Slobodien, Joseph F. Sandella, Marshall Smith, George Henderson, Charles Gandek. Judicial Medical Ethics Committee—Benjamin F. Slobodien, Chairman, Eugene J. Tyrrell, Ralph Siegel (for two years); S. David Miller, W. E. Sherman (for one year);

Delegates and Alternates for Three Year Term. Delegates—Sidney D. Becker, Charles H. Calvin, Malcolm M. Dunham, Ralph Siegel, Sol Gurshman, Gerard R. Gessner, Joseph F. Sandella, A. Shayevitz; Alternates—Cyril I. Hutner, Louis A. Perillo, Morton M. Klein, Edward Brezinski, Howard Slobodien, Bartley M. Howley, Alfred J. Barbano, Harold M. Fein; Delegate and Alternate to The Medical Society of New Jersey Nominating Committee for 1960—Charles H. Calvin and Gerard R. Gessner.

Following this, Dr. George J. Kohut, the retiring president, thanked his officers and committees for the fine cooperation which he received from them during the past year and turned over the gavel to Dr. John A. Smith of South River, the new president.

Dr. Smith, in his acceptance speech, stressed the importance of committees in the health of and standardization of procedures in the county. He believes that in the next year the County Society will be vitally concerned in setting up plans to secure adequate coverage for the population over 65 years of age. He requested that the members give this serious thought.

Dr. Gerard Gessner presented the retiring president, Dr. Kohut, with a Past President's Plaque for meritorious service to our Society.

After conclusion of the business meeting, members and their wives enjoyed an excellent floor show consisting of variety acts, comedians, music, singers, puppets and novelty acts followed by dancing.

DONALD T. AKEY, M.D.

Reporter

Marginalia of Medicine • • •

16

Dr. Leo Alexander, the distinguished Boston psychiatrist writes:

I was impressed with your editorial on "The Psychosomatic Dilemma," which appeared in The JOURNAL of The Medical Society of New Jersey, September 1958, and which was reprinted in *Current Medical Digest*, January 1959. The provocative ending "Solution Anyone?" stimulated me to an answer.

The solution is teamwork. As a psychiatrist I have collaborated in this manner with a number of internists and general physicians very successfully. I am of the opinion that the condition for successful work of this kind is that the two physicians involved should be on close friendly terms and should have profound respect for each other as to their competence in their respective fields. Naturally they are bound to trespass on each other's areas occasionally. But if the two physicians are on good friendly terms they can work this out with each other and with the patient, and in the course of this process the patient gets insight and learns to look at his problem from two points of view rather than from one narrowly limited one. After all, looking at things from two vantage points is basic for stereoscopic vision as compared to a unidimensional schematic line drawing.

17

In the April JOURNAL we asked for a euphemistic synonym for impotence. Dr. M. Eugenia Geib of Madison makes the following suggestions:

For weeks I have been pondering your request for a euphemism for impotence. The obvious suggestion is "Tired Love," but I am afraid that has been used; I remember seeing such a heading on an advertisement in an AMA exhibit on quackery.

"Limp—or Lax—Lechery" is a little too suggestive; "Paltry Passion" is perhaps not suggestive enough. How about "Fag End"?

I also thought of "Cold Feet," but that could be condemned as fraudulent use of the males.

Now I have a question for you. What is the noun of assembly for detail men? You may have noticed that they never come singly. Not only do they travel about in twos and threes like nuns, but also they seem to follow each other; more often than not, one finds V-Cillin-K glowering suspiciously across the waiting room at Pentids.

Perhaps there should be two words: the representatives from the same company might be a bluster, or a chatter, or a ballyhoo of detail men, while a group from competing firms could be a sampling, or a rivalry. What do you think?

Sincerely,

M. EUGENIA GEIB, M.D.

We opt for a "Chatter of Detail Men." Actually, they do not want to be called "detail men." They are service representatives. We have thought of a "covey of representatives," Or, since they do teach us what's new, a "school of detail men" or maybe a shoal.

It has been suggested that a smart pharmaceutical company might develop detail women instead of detail men. Then the collective noun could be bevy or flock. There might be other advantages, too, in distaff detailers. A coterie of service representatives! A galaxy, a cluster, a claque or a herd! When they seem to be pushing us to prescribe their products, we might call them a drove of representatives. And if they come in in swarms and fill our waiting room chairs then, by all means, a litter of detailers.

Obituaries

DR. DAVID B. ACKLEY

Death paid a call on June 14, 1959 at the home of Dr. David B. Ackley, formerly chief of staff of Mercer Hospital. Dr. Ackley received his medical degree from the University of Maryland in 1901. The following year he came to Trenton and was appointed to the clinic staff at the Mercer Hospital. He advanced rapidly and within eight years was chief of surgery at that hospital. Then in 1918 he became chief of staff, a position which he held for 35 years. Dr. Ackley was born in 1875.

The medical library at the Mercer Hospital is named for him. He was a Fellow of the American College of Surgeons and in 1906 was president of our Mercer County Medical Society. Last year he received the Golden Merit Award of The Medical Society of New Jersey. Dr. Ackley was known as a skillful golfer and a high-ranking bridge player. He was generally considered one of the leading surgeons in the Delaware Valley.

DR. REUBEN M. ANDERSON

Dr. Reuben M. Anderson, one of Bergen County's leading thoracic surgeons, died suddenly on June 14, 1959. Born in Michigan in 1896, Dr. Anderson received his M.D. from the University of Minnesota Medical School in 1925. After serving an internship in Minnesota, he came to New Jersey t take a residency at the Hackensack Hospital. H returned to Minnesota, where he did graduate wor in surgery at the Mayo Clinic for some years. D Anderson is credited with having been the prin mover in the creation of the Bergen Communit Blood Bank. He was a Fellow of the America Society of Thoracic Surgery and was active i many organizations. He was director of surger at Bergen Pines as well as chief of thoracic su gery both there and at the Hackensack Hospita He was also associate director of surgery at th Hackensack Hospital.

He was active in the American Legion, countr clubs, civic and medical society affairs.

DR. FRANCIS L. STOUTER

On June 13, 1959, Dr. Francis L. Stouter di suddenly at his home. Born in 1904 in Paterso he was graduated in 1931 from Georgetown. Du ing World War II he was a captain in the A Force. He also served as medical examiner f the Wright Aeronautical Corporation. He was vic president of the Holy Name Society of his parish Paterson. Dr. Stouter specialized in ophthalmolog and belonged to the State Ophthalmologic Associ tion. He was also active in the affairs of t Passaic County Medical Society.

Book Reviews

Convulsive Disorders of Children. Dora Hsi Chih Chao, M.D., Ralph Druckman, M.D. and Peter Kellaway, M.D. Philadelphia and London 1958. Saunders. Pp 150. ($6.00)

This is a beautifully organized review of the diagnosis, treatment and management of the convulsive disorders of childhood. It is concise and simple and based on data collected and developed at the Bluebird Circle Children's Clinic. The text reads like a brilliantly written notebook in which a student had succeeded in taking down every word of the lecturer's, in shorthand.

In the past, the classification of convulsive disorders has tended to be largely descriptive. The authors show the result of long term study of each variety of epilepsy. Starting with definitions and classification, the book goes on to anatomy and pathology, and later, to a description of the sequence of events in a seizure. A reader of this review may get an idea how thorough this book is merely by observing the titles: Symptomat epilepsy, Symptomatic seizures of childhood, Ma sive spasms, Idiopathic (genetic) epilepsy, Co vulsive equivalent attacks, Benign febrile convu sions, Breath-holding attacks, Epilepsy of adu life and Extracerebral factors. Each category described thoroughly, including pathology, labor tory aids and treatment.

The book includes chapters which will help t doctor investigate the seizure patients by taking detailed history. There is material here on electr encephalography where graphs are displayed ar are tied to histories. The last chapter is devot to the management of the seizures. This includ a valuable drug table, naming all the anti-convu sant drugs in use today and describing indication dosage toxicity and pharmaceutical firms man facturing them.

RALPH NEIL SHAPIRO, M.D.

Aids to Medical Diagnosis. By G. E. Sutton, M.D. Baltimore 1958. Williams and Wilkins. Ed. 8. Pp. 400. ($3.50)

Seven previous editions of this book testify to s acceptability. The volume is only 6½ inches ng and 4 inches wide—so that it fits neatly into e pocket or doctor's bag. It covers each of the dy systems—diseases of the lungs, diseases of e kidneys, and so forth, in systematic fashion. raditional "differential diagnosis" tables are ven. An enormous amount of factual data is rammed into the 400 pages. There are, for example, diagrams and tables showing differential iagnosis of aphasia, nerve supply to muscles, ectrocardiographic tracings, causes of swellings various parts of the abdomen and so on. Laoratory work-up is underemphasized, as Dr. Sutn prefers to highlight *clinical diagnosis*. The tyle is brisk and factual. All in all a solid, unexiting and usable little book!

ULYSSES FRANK, M.D.

The Story Behind the Word. Harry Wain, M.D. Springfield, Illinois, 1958, Thomas. Pp. 342. A Listing of Over 5000 Medical Words with the Stories Behind Each Word. ($8.50)

An accolade for Harry Wain who can, with wit nd charm, explain the story of our daily terms: liseases, places, tissues, germs: abdomen and amutate—Basedow and capitate; douche, elixir, fossa, raph, infarct, jelly, Klebs and laugh; melanoma, ucleation—oxygen and palpitation; pelvis, quack nd reflex action; sex, trachoma, urine fraction; agus, whiskey, x-ray, yeast!

Here's a welcome verbal feast: 5000 words are n display. This tells you how they got that way. And yet, in all, this book's a blight. I kept on leafng it all night.

HENRY A. DAVIDSON, M.D.

Psychotherapeutic Drugs. Anton L. Welsh, M.D. Springfield, Illinois 1958. Thomas. Pp. 139. ($4.75)

The rapid expansion of the tranquilizer field makes it risky to offer any book on the subject. The author here brings together in one slim volume a battery of facts about tranquilizers and energizers. Dr. Welsh covers indications, contra-indications and side-effects. The text is lucid, and the arrangement makes for ready reference. While the book may be outmoded as more drugs are made available, it stands now—and probably will for another year or two—as a most practical guide to a bewildering subject. A bibliography of 278 references adds to its usefulness.

HERBERT BOEHM, M.D.

The Birth of Normal Babies. Lyon P. Strean, D.D.S., Ph.D. New York, 1958. Twayne Publishers, Inc. Pp. 194. ($3.95)

In spite of its title, this is a book about abnormal, not normal births. The author's thesis is that stress during pregnancy accounts for still-births, birth defects and miscarriages. Included under "stress" are such things as poison ivy, getting penicillin, and "unpleasant environment." To prevent stress during pregnancy, the author recommends vitamins, and urges the woman to avoid high altitude flying, tooth extractions, emotional stress and x-rays. In discussing the need for emotional tranquility, the author writes ". . . with loss of employment, though serious at times, one must not become frustrated and feel that the world has come to an end. The time (while idle) could be spent to greater advantage by finding out ways and means of acquiring new employment. Careful budgeting frequently takes care of the rainy day. Behind every cloud there is a silver lining."

The author is not a physician.

VICTOR HUBERMAN, M.D.

A Doctor Remembers. By Edward H. Richardson, M.D. New York, 1959. Vantage Press, Inc. Pp. 252. Illus. ($3.95)

Dr. Richardson, Associate Professor Emeritus at Johns Hopkins, has written an interesting autobiography—one which blends the facts of his life with wit and wisdom. He tells in chatty style a success story in life and medicine. A Virginia farmboy who attended rural schools and later Hampden-Sydney College, the author received his M.D. degree from Johns Hopkins in 1905. His thumbnail sketches and anecdotes about Hopkins' 'famous four' in medicine, Drs. William H. Welch, William (later Sir William) Osler, William S. Halsted and Howard A. Kelly, are valuable reminiscences. Five additional years of postgraduate training in surgery and gynecology at Johns Hopkins Hospital are also set in the electrifying atmosphere of those great years in Baltimore before the first World War.

After fourteen years devoted to obtaining his education and specialty training—without any financial compensation—Dr. Richardson passed through a "crumbs" period in practice before gaining his "cakes and ale." A frank discussion of the full-time clinical faculty controversy, with personal opinions and reflections from over fifty years of practice and teaching make for good reading. Considerable technical discussion of surgical procedures and participation in medical society activities may make parts of this volume rather turgid reading for the non-professional.

A Doctor Remembers is a self-portrait by a complete man, and a book which a fellow medico is particularly likely to enjoy.

FRED B. ROGERS, M.D.

Vascular Surgery. By Geza de Takats, M.D. Philadelphia 1959. Saunders. Pp. 726. Illus. 382. ($17.50)

Any new work published on an increasingly important medical and surgical specialty such as peripheral vascular disease is most welcome; more so if written by an authoritative pioneer like Geza de Takats.

The author properly states that, "In these times of rapid technical advances, it is almost inevitable that a monograph embodying many technical procedures be out of date in some respects even on the day of its publication." This is already true of this publication, *Vascular Surgery.*

In a monograph, an author presents his own views, personal preference and experiences. In a text book for students and specialists in the field, an entirely different treatment of material is indicated. This monograph is too advanced for the beginner. For a specialist, it does not add spectacularly to the current concepts of the field. For example, in the chapter on diagnostic aids, mention is made of many technics which are fast becoming obsolete. In the discussion of therapy for organic occlusive diseases, too much emphasis is placed on sympathectomy as a therapeutic procedure. With the replacement of homografts by plastic prostheses, much is said about the former which is no longer pertinent. The last third of the book consists of illustrations of surgical procedures. The drawings are of good caliber but the discussions are meager.

This monograph is an excellent addition to a peripheral vascular library. However, the great American book on peripheral vascular disease has not yet been written.

JACOB SCHMUKLER, M.D.

Bone Tumors. By Louis Lichtenstein, M.D. St. Louis 1959. C. V. Mosby Co. Pp. 402. Illus. 220. 2nd edition. ($12.00)

As an ex-student of Dr. Lichtenstein's, it gives me pleasure to comment on the new edition of this work. It comes seven years after the original and contains 220 illustrations as compared to 155. He has added a "Foreword to Pathologists" which gives a few hints to pathologists dealing with bone tumors. He shows the necessity for a complete clinical picture including history and x-rays and the need for proper tissue specimens and their preparation. He emphasizes his wariness towards frozen sections and needle biopsies. He includes a new chapter entitled "General Remarks on the Clinical Management of Bone Lesions that may be Tumors." He has changed his classification of osteogenic fibromas to "benign osteoblastomas." Dr. Lichtenstein has added a chapter entitled, "Tumors of Periosteal Origin." There is a new index on "Tumors of Synovial Joints, Bursae and Tendon Sheaths." This brings the new edition to 402 pages as compared with 315 pages in the old edition.

Much of the material of the original edition is used, including plates and descriptions. In Chapter IX on "Benign Osteoblastoma" we now have seven full descriptive pages instead of three, a portion of which represents the clinical features of the lesion. Thus Dr. Lichtenstein has made the volume unusually valuable to the practitioner as well as the pathologist. The classification of bone tumors in the new edition is virtually identical with that in the old. The author has removed the question mark after liposarcoma suggesting a more positive attitude towards that tumor. He has added to the content on the chapter, "Non-Osteogenic Fibroma of Bone" as well as presenting a few additional fine plates. The tissue plates are especially fine. Many new ones have been added, as for example the excellent one of a glomus tumor. Virtually all chapters have been enlarged somewhat both in text and in plate content.

Dr. Lichtenstein has fully justified the publication of this new edition. It is done in his usual clear, concise and orderly fashion and is a "must" for all medical libraries.

JARVIS M. SMITH, M.D.

Patient Care and Special Procedures in X-Ray Technology. Carol H. Vennes, R. N. and John C. Watson, R.T. St. Louis. Mosby. Pp. 203.

Until the advent of this book, texts available to the x-ray technician were concerned wholly with the "mechanics" of taking radiographs, *viz*: positioning of patient, number and types of radiographic views and the physical factors needed to produce these radiographs (Kvp, Ma, time, distance, etc.)

Here for the first time, presented in readily understandable language, is a text setting forth the principles of patient care as they relate to x-ray procedures. How the technician can best handle the anxious, apprehensive patient, the unconscious patient, the injured patient, the aged and senile patient both in the x-ray department and in bedside procedures, is clearly and simply "spelled out." In addition to the routine examinations such as gastro-intestinal series, barium enemas, intravenous pyelography, the less widely used myelography, encephalography, angiography, etc., as well as operating room technics are covered. Pertinent illustrations are included.

This book will fill a real need in the training of technicians and should be available to them both within hospitals and in all offices concerned with radiography.

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References: 1. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 2. Charles, C. M.: Geriatrics 2:110 (March) 1956. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956. 4. Dolowitz, D. A.: Rocky Mountain M. J. 55:53 (Oct.) 1958.



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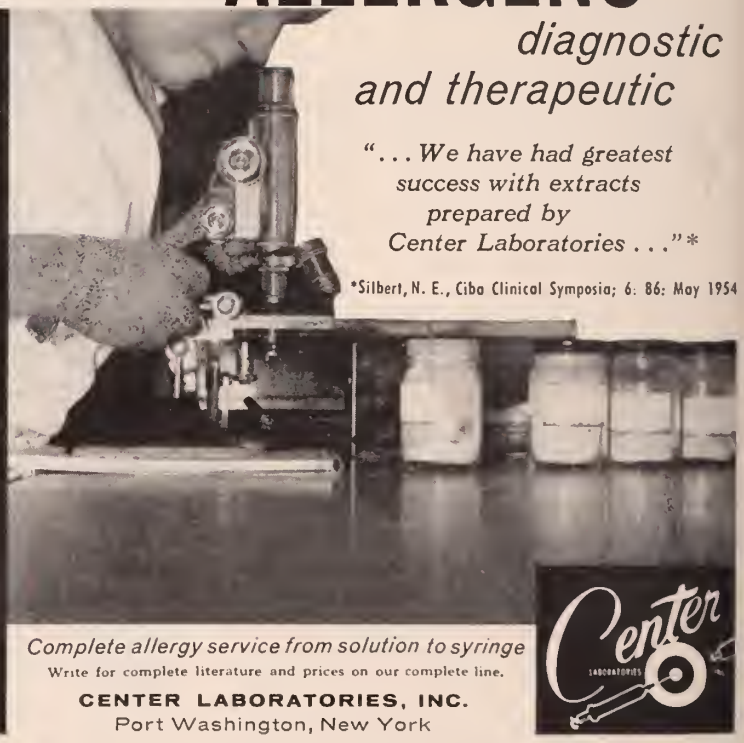
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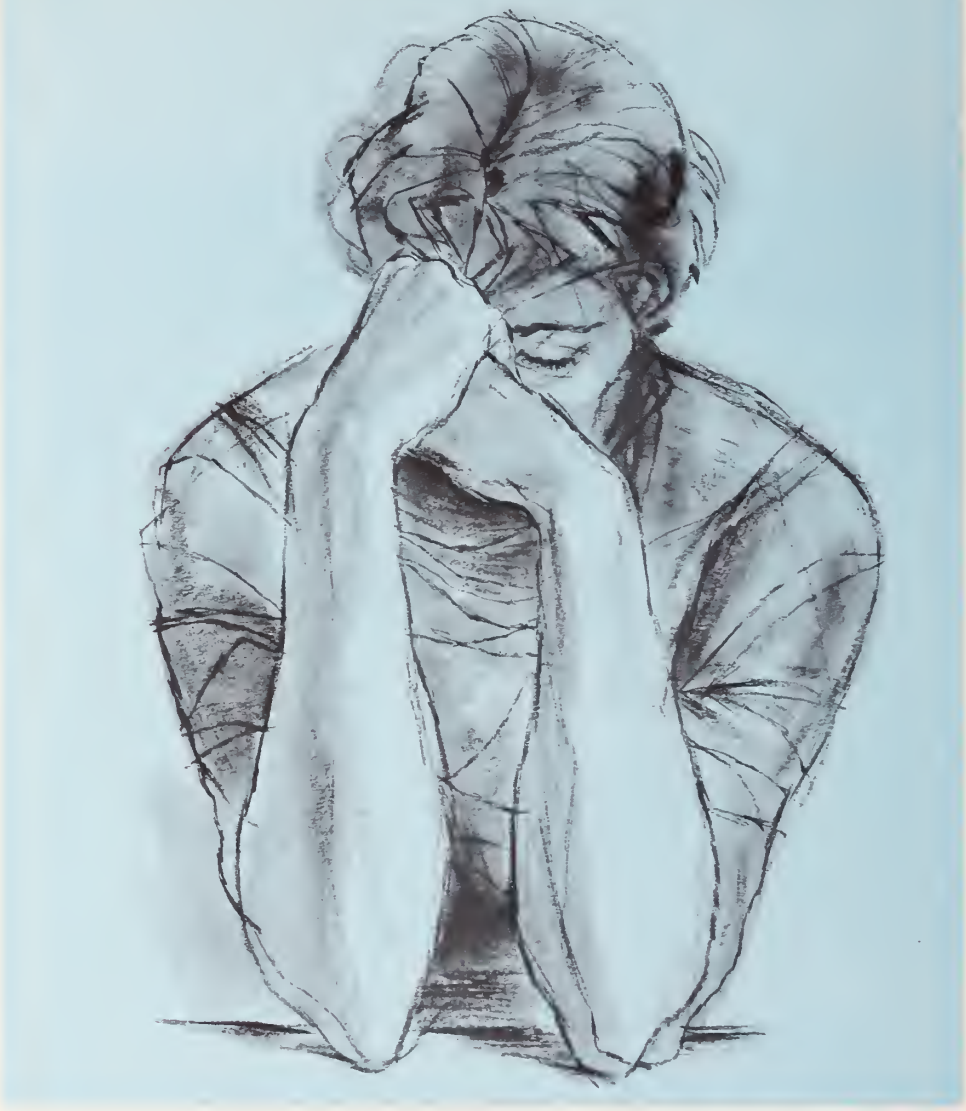
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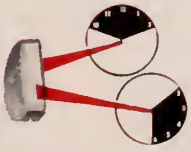
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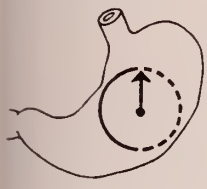
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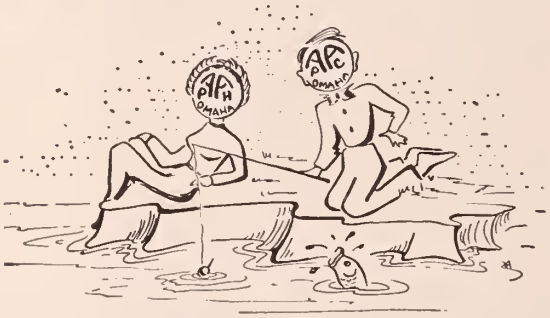
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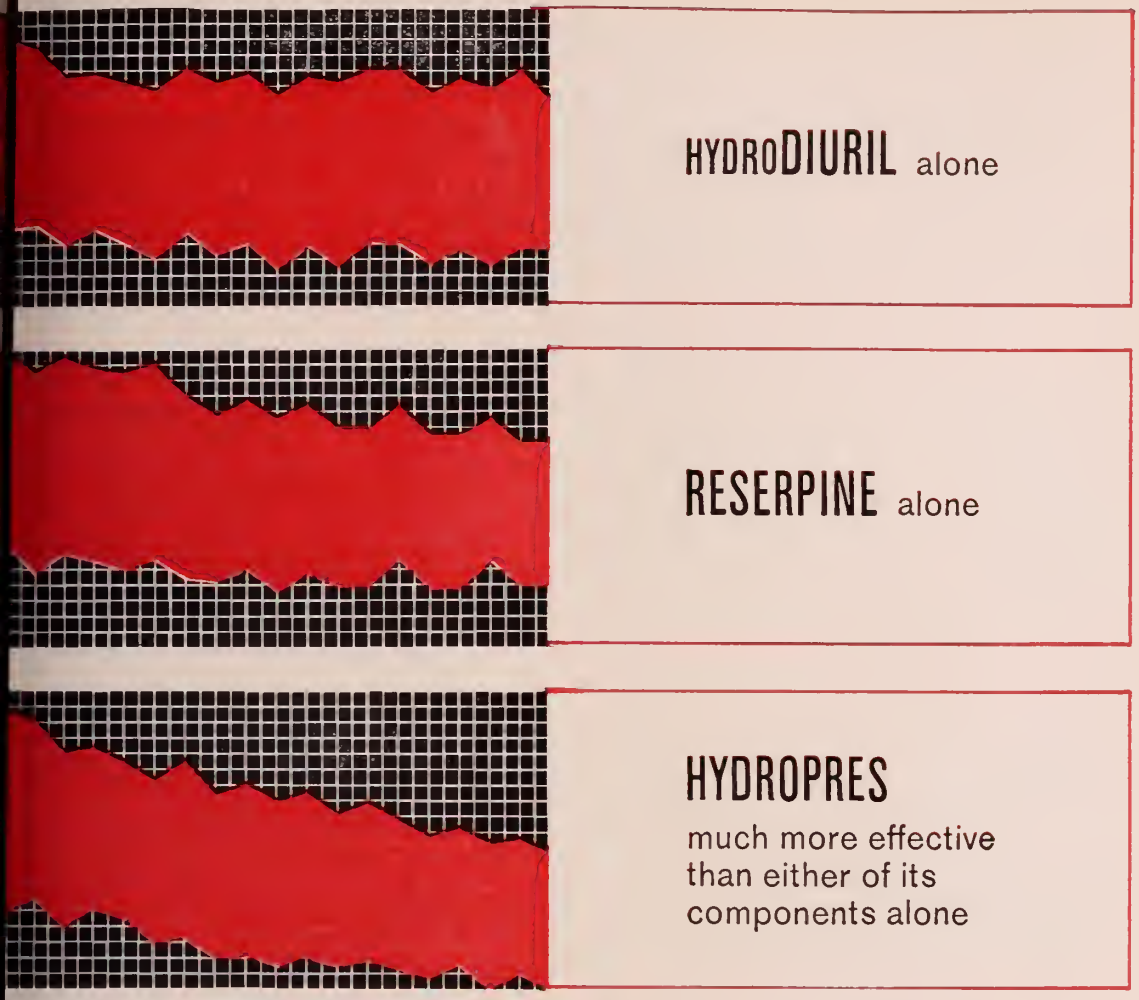
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CONTENTS—Pages 529 to 588

TORIALS— Page
The Unintended Guinea Pig 529
The Fading Imagery of Medical Words 530
Medical Teaching to Lawyers 531

IGINAL ARTICLES—
Inguinal Hernia—Roswell K. Brown, M.D., Buffalo, N. Y. 532
Emergency Management of Maxillo-Facial Injuries—William C. Conroy, M.D., D.D.S., Montclair, N. J. 538
Peptic Ulcer in the Aged—Stuart A. Mason, M.D., Ridgewood, N. J. 542
Pruritus—Joseph E. Higi, M.D., East Orange, N. J. 545
Aminophylline Poisoning in Childhood—Roy Pollack, M.D., Englewood, N. J. 550
Jaundice Precipitated by Prochlorperazine—Archie Crandell, M.D. and John Y. Ma, M.D., Greystone Park, N. J. 553
Liothyronine as a Replacement for Thyroid Therapy—Rita Finkler, M.D., Newark, N. J. 555

ORIGINAL ARTICLES— Page
Clinical Aspects of Diarrhea—William Z. Fradkin, M.D., Brooklyn, N. Y. 558
Physiotherapy and Rehabilitation—F. Clyde Bowers, M.D., Mendham, N. J. 563
Penetrating Abdominal Wound—James B. Ridley, M.D., Englewood, N. J. 566

STATE ACTIVITIES—
Trustees' Meeting 568
Organization Structure of The Medical Society of New Jersey 572
Do You Have Any Cases of Sjogren's Syndrome? 578

OBITUARIES 579
ANNOUNCEMENTS 580
COUNTY SOCIETY REPORTS 582
CIVIL DEFENSE ITEMS 583
BOOK REVIEWS 584
NTA ABSTRACTS 587

Roster of Officers and Committees, Advertising Pages 3A - 6A

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(The complete terms of the insurance coverage are set forth in the policy)

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30	60.00	30.60	42	96.00	49.00	54	205.00	104
31	63.00	32.10	43	99.00	50.50	55	230.00	117
32	65.00	33.20	44	103.00	52.50	56	250.00	127
33	67.00	34.20	45	107.00	54.60	57	265.00	135
34	70.00	35.70	46	113.00	57.60	58	280.00	142
35	73.00	37.20	47	124.00	63.20	59	295.00	150
36	77.00	39.30	48	136.00	69.40	60	315.00	160
37	80.00	40.80	49	148.00	75.50	61	330.00	168
38	83.00	42.30	50	160.00	81.60	62	345.00	176
39	87.00	44.40	51	175.00	89.30	63	360.00	183
40	90.00	45.90	52	185.00	94.40	64	375.00	191

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☞ widest latitude of safety and flexibility

No serious adverse reaction ever documented – five dosage forms and sizes

☞ chemically distinct among tranquilizers

Not a phenothiazine or a meprobamate

☞ added frontiers of usefulness

These unique benefits in specific indications

ANTIHISTAMINIC
ANTIARRHYTHMIC
ANTISECRETORY

BACKED BY A WORLD OF EXPERIENCE

Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN – 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

ATARAX®

(hydroxyzine)

PASSPORT TO TRANQUILITY

PFIZER Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

day and night—ulcer control with **B.I.D.** *dosag*



Just one 10 mg. Daricon tablet in the morning, and one at night before retiring, ke your patient free from the pain and discomfort caused by gastrointestinal spasm, hyp motility, and hypersecretion.

Daricon is a remarkably potent and well tolerated antisecretory/antimotility agent. *naturally* prolonged action provides day and night relief of pain and symptoms associa with peptic ulcer, functional bowel syndrome, biliary tract dysfunctions, and other gastro testinal disorders characterized by spasm, hypermotility, and hypersecretion.

EVEN REFRACTORY CASES RESPOND

new **DARICON**

oxyphencyclimine hydrochloride

Pfizer *Science for the world's well-being*™

Pfizer Laboratories
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

References: 1. Finkelstein, M., et al.: J. Pharma & Exper. Therap. 125:330 (April) 1959. 2. McHar G., et al.: Postgrad. Med., in press. 3. Winkelstein, Amer. J. Gastroenterol., in press. 4. Finkelstein, et al.: Presented at Fall Meeting, Amer. Soc. Pharma & Exper. Therap., 1958. 5. Leming, B.: Clin. M 6:423 (March) 1959.

•Tradem

STOP

running noses



and open stuffed noses orally

Triaminic®

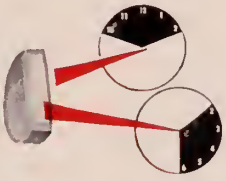
the leading oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

safer and more effective than topical medication[1,2,3]

- systemic transport to all respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each TRIAMINIC Tablet provides:
Phenylpropanolamine HCl .....50 mg.
Pheniramine maleate .....25 mg.
Pyrilamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to ¼ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



when it's skin deep

use XYLOCAINE *ointment*

. . . in nearly all external symptoms of *pain*, *itching* and *burning*, e.g., sunburn, minor burns, insect bites, abrasions, poison ivy and other contact dermatitis, hemorrhoids and inoperable anorectal conditions, and cracked nipples.

Xylocaine Ointment, a surface or topical anesthetic, gives fast, effective and long lasting relief. Its *water-soluble, nonstaining* base melts on contact with the skin, to assure immediate release of the anesthetic for fast action and it does not interfere with the healing processes.

ASTRA PHARMACEUTICAL PRODUCTS, INC., WORCESTER 6, MASS., U.S.A.

XYLOCAINE® OINTMENT

(brand of lidocaine*)

2.5% & 5%

SURFACE ANESTHETIC

SEE PDR

*U.S. Pat. No. 2,441,498 Made in U.S.A.



waterloo for an ulcer...

exhibited ulcer symptoms through most of life, yet he scorned medication for his ever-pasms of nervous origin." He ignored his with violent naïveté despite an intense in-medical science. Thus, the classic hand-in- may have been the result of his paroxysms pain that sliced "like the stab of a penknife."

our patient is besieged with an ulcer, provides you with an armamentarium to repel it.

assault—If your tactics dictate Local try ROBALATE,® which is dihydroxy m aminoacetate (0.5 Gm. per tablet or n antacid of definitely superior efficacy.

ement – If you prefer to approach the stemically, prescribe TAL,® the anticho-linergic-antispasmodic-sedative with the time-tested *natural* belladonna alkaloids and phenobarbital, a veteran campaigner without peer. FORMULA: hyoscyamine sulfate, 0.1037 mg.; atropine sulfate, 0.0194 mg.; hyoscine hydrobromide, 0.0065 mg.; and phenobarbital (¼ gr.), 16.2 mg.

multi-pronged attack – If you relish the strategy of combining antacid and antispasmodic-anticholinergic effects, use DONNALATE.® It combines one-half of a DONNATAL tablet with one ROBALATE, ideal allies for comprehensive ulcer therapy.

Victory will be yours.

A. H. ROBINS CO., INC. • RICHMOND, VA.

DONNALATE®

Robins

wherever there is inflammation, swelling, pain

VARIDASE®

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery. By activating fibrinolytic factors VARIDASE shortens the *undesirable phase*, limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.
Dosage: One tablet four times daily usually for five days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.
Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.
Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York





URY
ises
lling
ared
day[2]



VARICOSE ULCER

15 years duration ... resolved with VARIDASE[1]





INFLAMMATORY DERMATOSIS

rapidly spreading rhus dermatitis healed within a week[1]





ECTED
ATION
versal
ys...
urned
ool...
anced[1]





THROMBOPHLEBITIS

back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS

normal routine resumed after 4 days of VARIDASE[1]



CLASSIC CONCEPTS

"Pure gastric juice, when taken directly out of the stomach of a healthy adult, unmixed with any other fluid, save a portion of the mucus of the stomach with which it is most commonly and perhaps always combined, is a clear, transparent fluid; inodorous; a little saltish, and very perceptibly acid."
—WILLIAM BEAUMONT, M.D., 1833



MODERN THERAPY

drink, and be merry...

Someth ng like Sedalin has always been needed because of mank nd's eterna wish to eat, drink, and be merry. Indeed, hyper-acidity – generally the result of such over-gence – has been and is so common among all peoples of the world that some of them ha e a virtue of necessity and turned the gaseous eructation into a compliment. But with Seda in a compromise is no longer necessary, because this new antacid rapidly neutralizes 141.0 cc. N hydrochloric acid with each tablespoonful. It maintains a desirable pH range that relieves atient of symptoms in the shortest possible time. And Seda in is not constipating, contains no m, and is not in any sense an astringent. Sedalin is exceptionally pleasing to the taste – so ng, in fact, that it can be taken indefinitely without loss of palatability. We think you will find atients pleased if you recommend this latest development in the search for the ideal antacid.

new Sedalin

ntacid

Each tablespoonful (15 cc.) contains
5 grains of aluminum hydroxide, 3 grains of magnesium trisilicate,
4 grains of calcium carbonate and 4.5 grains of magnesium hydroxide,
in a specially prepared demulcent base.

Dosage: Adults—1 tablespoonful; if needed, repeat every half hour.
Children—5-11 years, 1 teaspoonful; 11-15 years, 2 teaspoonfuls;
if needed, repeat every half hour. Supply: 12 oz. bottle.

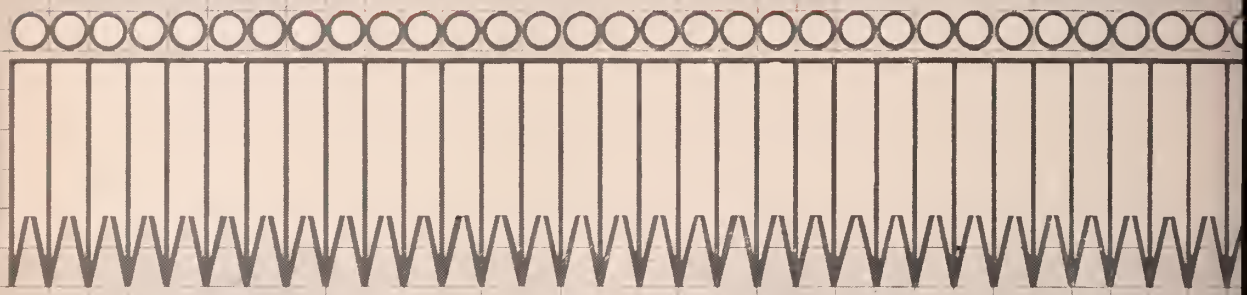


Pharmaceuticals, Inc., New York 22, N. Y.

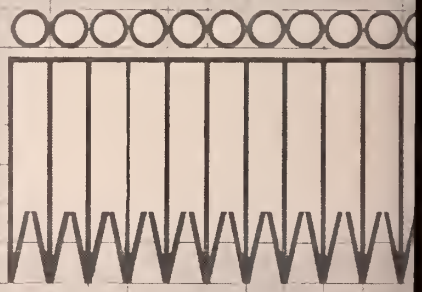
Decadron®

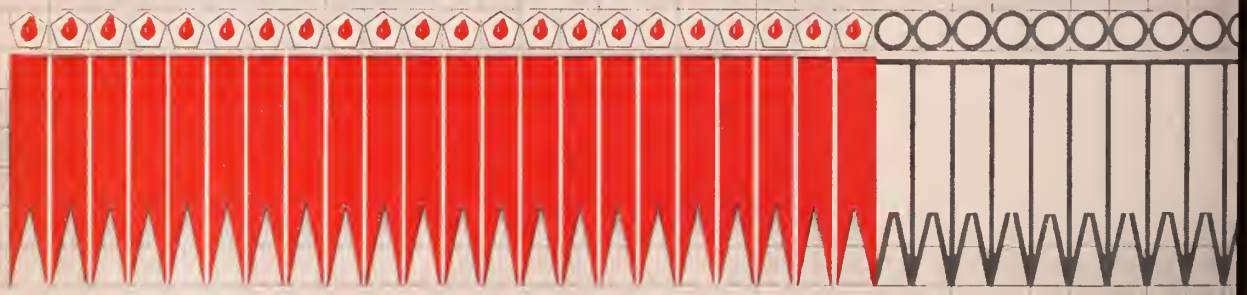
DEXAMETHASONE

treats more patients more effectively...

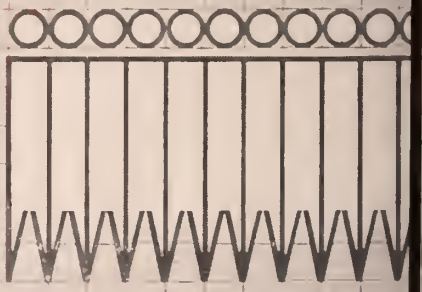


Of 45 arthritic patients
who were refractory
to other corticosteroids*





22 were successfully
treated with **Decadron**[1,2]



1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

DECADRON is a trademark of Merck & Co., Inc.

Additional information on DECADRON is available to physicians on request.

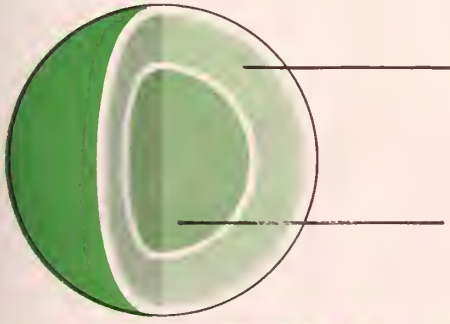
Merck Sharp & Dohme

DIVISION OF MERCK & CO., Inc., PHILADELPHIA 1, PA.



the complaint: "nervous indigestion"

he diagnosis: any one of several nonspecific gastrointestinal disorders requiring relief of ymptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy. **he prescription:** a new formulation, incorporating in a single tablet the actions of Donnatal nd Entozyme. **the dosage:** two tablets three times a day, or as indicated.



the formula: *in the gastric-soluble outer layer:*

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (⅛ gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

in the enteric-coated core:

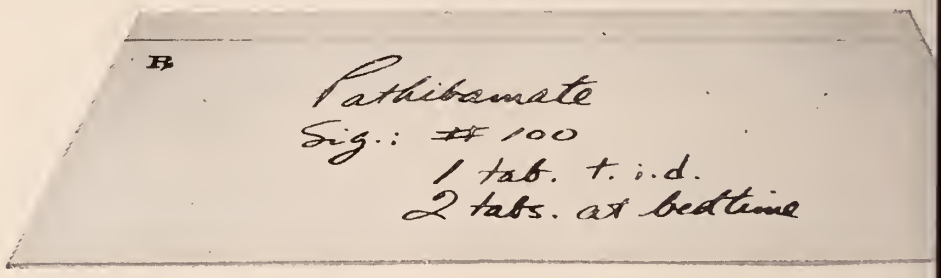
Pancreatin, N.F.	300 mg.
Bile salts	150 mg.

DONNAZYME™

Robins

. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA

for the control of tension and G.I. trau
many of you have been writing this
prescription in increasing numbers fo
nearly two years . . .

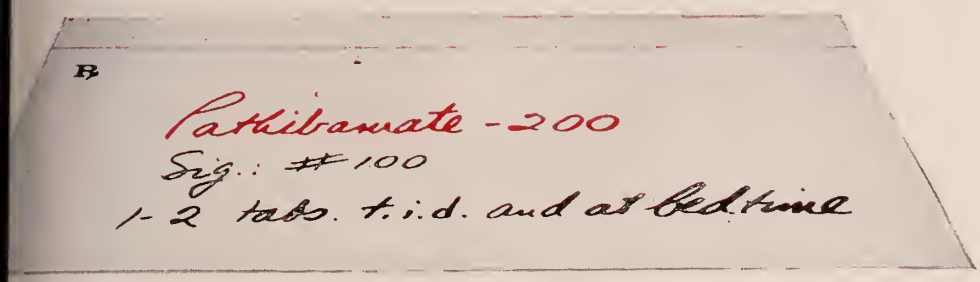


predictable results
in the control of
tension and G.I. trauma

PATHI

Lederle LEDERLE LABORATORIES, A

W! for greater flexibility in the control of tension and G.I. trauma... now you can write:



management of such gastrointestinal
nctions as duodenal or gastric ulcer,
nal colic, spastic and irritable colon,
esophageal spasm, gastric hyper-
ty and anxiety neurosis with G. I.
oms, nearly two years' experience has
med the clinical advantages derived
the combination of the two agents in
IBAMATE.

New PATHIBAMATE-200 Tablets combine Meprobamate at one-half strength, with PATHILON at full established potency.

With PATHIBAMATE-200, further individualization of treatment is facilitated in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: PATHIBAMATE-400 — Each tablet (yellow, ½ scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.
PATHIBAMATE-200 — Each tablet (white, coated) contains Meprobamate, 200 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

Administration and dosage: PATHIBAMATE-400 — 1 tablet three times a day and 2 tablets at bedtime.
PATHIBAMATE-200 — 1-2 tablets three times a day and at bedtime. Adjust dosage to patient response.

MATE® 400 200

Meprobamate with PATHILON® Tridihexethyl Chloride* LEDERLE

HILON is now offered as tridihexethyl chloride instead of the iodide, since the latter may interfere with the results of certain thyroid function tests.

ICAN CYANAMID COMPANY, Pearl River, New York



Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.

nauseated or vomiting patients
respond quickly and routinely to

Trilafon®
perphenazine

MUCH MORE ACTIVE ANTIEMETIC effect per milligram dosage than with other phenothiazines

MINUS the danger of significant hypotensive reaction

PLUS maintenance of alertness and regular activity

MINUS pain or irritation on deep IM injection

PLUS convenient administration with one of 5 dosage forms (TRILAFON Injection, Suppositories, Syrup, REPETABS,® Tablets)

PROVED CONTROL OF VOMITING OR NAUSEA ASSOCIATED WITH

INFECTION
(*e.g.*, gastroenteritis, pyelitis)

DRUG THERAPY
(*e.g.*, digitalis, nitrogen mustard, aminophylline)

TOXICOSIS
(*e.g.*, uremia, diabetic acidosis, leukemia, carcinomatosis)

MORNING SICKNESS

HYPEREMESIS GRAVIDARUM

OPERATIVE PROCEDURES

MENIERE'S SYNDROME

RADIATION SICKNESS

PSYCHOGENIC PHENOMENA

S 273



SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY *Schering*

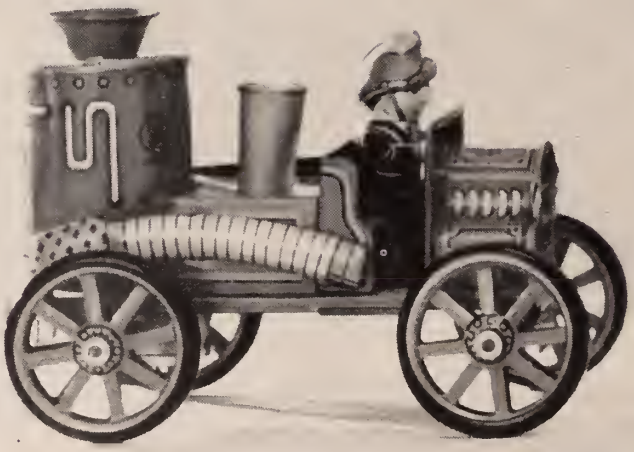
inflammatory-suppressive

inflammatory-corrective

antiallergic

antirheumatic

new, exclusive



Prednis-CVF

dual anti-inflammatory

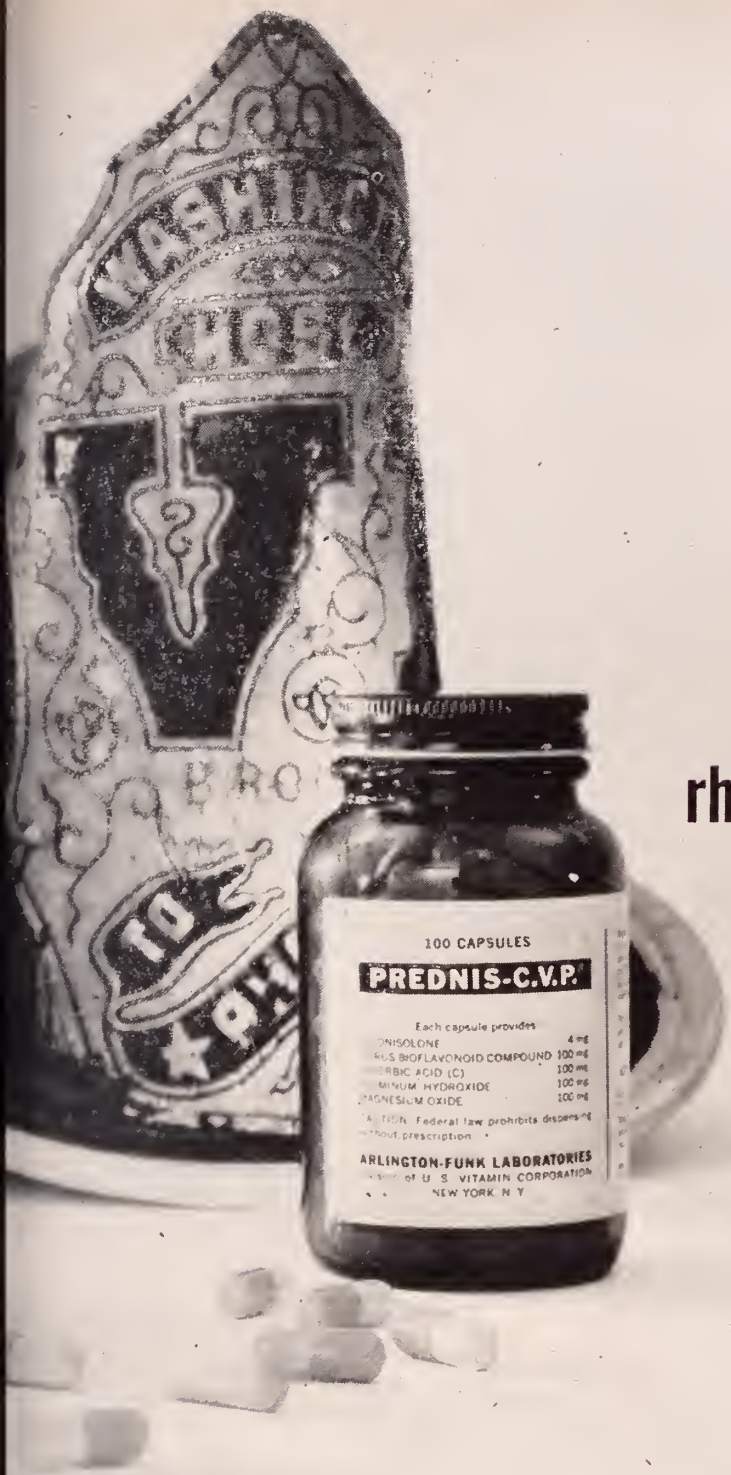
inflammatory-suppressive . . .
potent, prompt, sustained action with prednisolone

inflammatory-corrective . . .
reduction of abnormal capillary permeability with citrus bioflavonoids

"built-in" protection

with citrus bioflavonoids . . .
against ecchymoses, purpura gastric hemorrhage and othe steroid-induced capillary dam

with antacids . . .
against gastric distress, digestive upsets, nausea



in rheumatoid arthritis bronchial asthma eczemas

and other inflammatory, allergic and rheumatic conditions

ggested dosage:

erage initial dose,
o 5 capsules daily,
divided doses;
severe cases, 6 to 10
osules daily. Gradually
luce dosage to effective
intenance level.

tles of 30, 100 and
0 capsules.

mples and literature from

rlington-funk laboratories

Each **PREDNIS-C.V.P.** capsule provides:	
PREDNISOLONE	4 mg.
CITRUS BIOFLAVONOID COMPOUND	100 mg.
ASCORBIC ACID (C)	100 mg.
ALUMINUM HYDROXIDE	100 mg.
MAGNESIUM OXIDE	100 mg.

If one . . . or all . . . needs nutritional support . . .



they
deserve

GEVRAL®

capsules—14 VITAMINS AND 11 MINERALS

Vitamin-Mineral Supplement Lederle

For Complete Formula see PDR (Physicians' Desk Reference), page 689

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



Each tablet contains: Iron (Ferrous Sulfate Exsiccated 194 mg.), 58 mg.; Dioctyl Sodium Sulfosuccinate, 100 mg.; Vitamin A, 6000 U.S.P. Units; Vitamin D, 400 U.S.P. Units; Vitamin B_1 (Thiamine Mononitrate), 5 mg.; Vitamin B_2 (Riboflavin), 5 mg.; Vitamin B_6 (Pyridoxine HCl), 2 mg.; Vitamin B_{12} Activity (Cobalamin Conc.), 2 mcg.; Vitamin C, 100 mg.; Folic Acid, 0.25 mg.; Niacinamide, 20 mg.; Calcium Pantothenate, 5 mg., Calcium (Calcium Carbonate), 150 mg.; (Phosphorus free formula).

strength and vitality...
freedom from constipation



*TERMINATAL® (Tablets, Benton)

prenatal dietary supplement
high iron content in a potent nutritional formula
counteracts prenatal constipation
sensibly packaged in re-usable nursing unit
one-a-day dosage convenience

Addition of dioctyl sodium sulfosuccinate to offset constipation of pregnancy by fecal softening makes TERMINATAL a *unique* high-potency dietary supplement for use to term.

Supplied: 100 TERMINATAL capsule-shaped tablets are packaged in a useful nursing bottle with nipple, ready for the infant's first formula.

BENTON Laboratories Hatboro, Pennsylvania
Division of Air-Shields, Inc.



OFFERS HIGHER BLOOD LEVELS—FASTER—THAN ANY OTHER SALT OF ORAL PENICILLIN:

COMPOCILLIN®-VK

Potassium Penicillin V

Supplied: Compocillin-VK Filmtab 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units) bottles of 25 and 100. Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. When reconstituted, each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

ABBOTT

in tiny, easy-to-swallow Filmtabs® in tasty, cherry-flavored Oral Solution

"But, Doctor, I just can't swallow a lot of tablets"

"Little mother, just

ONE

BONADOXIN®

tablet stops morning sickness (you take it at bedtime)"



he formula tells why BONADOXIN quickly stops nausea and vomiting of regnancy in 9 out of 10 cases.* Each tiny BONADOXIN tablet contains: clizine HCl (25 mg.) for antinauseant action / Pyridoxine HCl (50 mg.) for metabolic replacement

ore than 60,000,000 tablets prescribed and taken. Toxicity low, tolerance cellent. In bottles of 25 and 100. Usual dose: one tablet at bedtime; severe ses may require another on arising. See PDR, p. 779.

NADOXIN also effectively relieves nausea and vomiting associated with: esthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral rteriosclerosis and motion sickness.

After Baby Comes

For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.*

Each cc. contains:
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

*Bibliography available on request.

New York 17, New York • Division, Chas. Pfizer & Co., Inc. • Science for the World's Well-Being

for Spastic Tension States

SED-TENS

TY-MED*



- FOR RELAXING THE SPASTIC G.I. TRACT
- FOR RELIEF OF NAUSEA IN PREGNANCY

Each Tablet Contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

DOSAGE: 1 tablet morning and night

CAUTION: Federal law prohibits dispensing without prescription.

*Ty-Med—Lemmon Brand of Timed-Release Medication.

LEMMON Pharmacal Co.

SELLERSVILLE PENNA.

TIMED-RELEASE . . . AT ITS LEVEL BEST

Doctors' Dilemma, 1959

he challenge of chronicity
n genitourinary tract infections

Aside from the disturbing increase in emergence of antibiotic resistnt bacterial strains, perhaps the most challenging dilemma conronting thoughtful physicians today is the problem of chronic nfection of the genitourinary tract."[1]

o control the chronic case

FURADANTIN®

and of nitrofurantoin

ay be used for protracted periods for the suppression of infection the urinary tract, even in the presence of probable obstruction."[2]

- Rapidly bactericidal against a wide range f gram-positive and gram-negative bacteria ncluding organisms such as staphylococci, roteus and certain strains of Pseudomonas, sistant to other agents
- Development of bacterial resistance has ot been a problem in over 7 years of extenve clinical use
- No cross-resistance or cross-sensitization ith other drugs since FURADANTIN, a synetic nitrofuran, is unrelated chemically to ny other class of antimicrobial drugs
- Excellent tolerance—no toxic effects on idneys, liver or blood-forming organs have ver been reported
- "The drug was given continuously and afely for as long as three years."[3]

vailable as Tablets, 50 and 100 mg.; Oral uspension, 25 mg. per 5 cc. tsp.

ferences: 1. Lipscomb, H., et al.: South. M. J. 52:16, 59. 2. Jawetz, E., et al.: A.M.A. Arch. Int. M. 100:549, 57. 3. Lippman, R. W., et al.: J. Urol., Balt. 80:77, 1958.

TROFURANS—a *unique* class of antimicrobials—ither antibiotics nor sulfonamides

ATON LABORATORIES, NORWICH, NEW YORK

avoid the risk of insoluble irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4, 5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded betw rugae. Reactions varying from mild hyperer to erosive gastritis have been reported to oc in the areas immediately surrounding th adherent particles.[2, 4, 5] This is reported to particularly true in patients with peptic ulc

CALURIN is the freely soluble, stable calcium aspirin complex. high solubility forestalls gastric irritation or damage

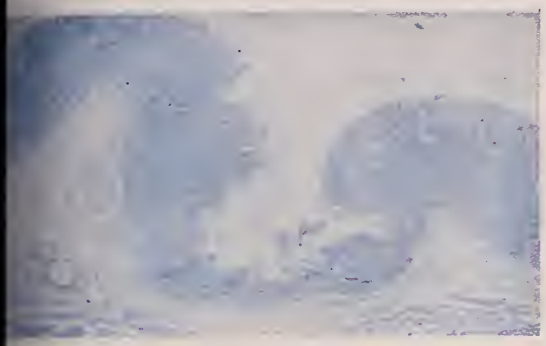


Regular aspirin crystals 24 hours after being mixed into water.

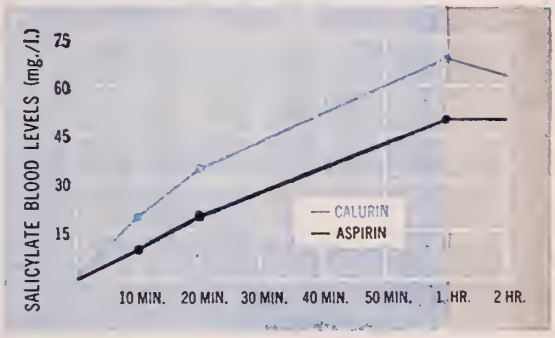
Calurin crystals in solution one mi ute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. **2**:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet **2**:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. **80**:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. **2**:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet **1**:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology **33**:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. **258**:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. **258**:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. **1**:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE



why should the urine be tested for sugar in acute cholecystitis?

The high incidence of pancreatic disease associated with pathologic conditions of the biliary tract indicates their close relationship. The appearance of glycosuria in acute cholecystitis points to involvement of the pancreas in the inflammatory process.

Source: Refresher Article: Biliary Tract Diseases, M. Times *85*:1081, 1957.

to help forewarn of pancreatic involvement...
and for reliable urine-sugar testing at any time

color-calibrated CLINITEST® BRAND Reagent Tablets

"...the most satisfactory method for home and office routine testing...."
GP *16*:121 (Aug.) 1957.

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- STANDARDIZED SENSITIVITY...avoids insignificant trace reactions

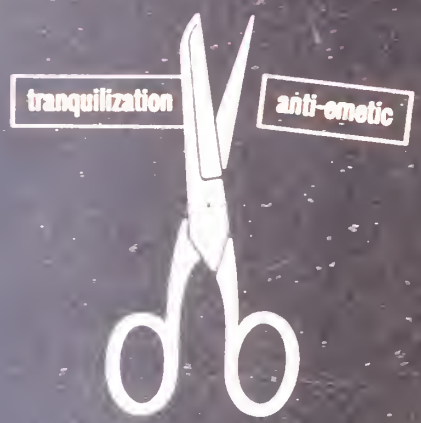
consistently reliable results
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test after test

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now potent tranquilizer therapy is safer than ever



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

- **jaundice**
- **Parkinsonism**
- **blood dyscrasia**

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has bee almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, derma even when given in quantities far in excess of the usual dosage.

"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responded reduction in dosage. Other side effects did not occu It is singularly free from the side effects ordinarily with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common administration of the phenothiazines, was present du the period of Thioridazine administration: Parkin ism or Parkinson-like symptoms, photosensitivity, o static hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaun and photosensitivity have not been observed in pati treated with Thioridazine [Mellaril]. Extrapyram side effects produced by other phenothiazines disappeared promptly with no deterioration in the havioral response when these patients have been sh to Thioridazine."[5]

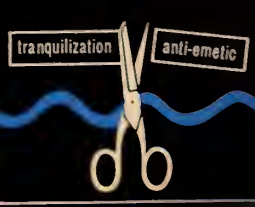
NO JAUNDICE

"No allergic reactions were observed such as skin e tions, jaundice or agranulocytosis. Central ner system toxicity, as manifested by extrapyramidal eff seizures, and excitement did not occur despite the of high doses (up to 2000 mg.) of the drug."[6]

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

EXTREMELY SATISFACTORY ". . . produced extremely satisfactory results in the broad therapeutic range represented in this series."[3]

POTENT AGENT ". . . appears to be a potent agent in the symptomatic management of a variety of psychiatric states."[4]

MAJOR ADDITION TO THERAPEUTICS "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

AN ACTIVE AGENT "Thioridazine is an active therapeutic agent. . . . It is effective in a variety of psychiatric disorders, including schizophrenic reactions. . . . The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."[6]

EVEN IN VERY SEVERE CASES "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."[7]

EXCELLENT THERAPEUTIC RESPONSE "Patients with emotional tensions resulting from the stress and strain of life . . . were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."[8]

"...extremely satisfactory results..." in a clinical spectrum ranging from minor nervous disorders to severe psychotic disturbances[3]

RESULTS WITH MELLARIL IN 194 PATIENTS[3]

ACUTE PSYCHOTICS	CHRONIC PSYCHOTICS	NEUROTICS
83% satisfactory effect	68% satisfactory effect	57% satisfactory effect
Some cases had complete remission of symptoms. Most were able to return home to useful occupations.	Relief of symptoms in cases permitted easier management and a return to a more or less useful life.	Some cases, complete relief of symptoms. Other cases, partial relief of symptoms.

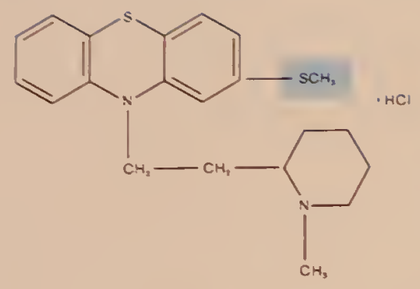
RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS[3]

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
SCHIZOPHRENIA				
Acute	89	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
CHRONIC BRAIN SYNDROME	66.6	33.3	33.3	33.3
CHRONIC PSYCHONEUROSIS	62.5	12.5	50	37.5
CHRONIC PSYCHOSOMATIC DISORDERS	75	25	50	25

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THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels
tranquilization anti-emetic

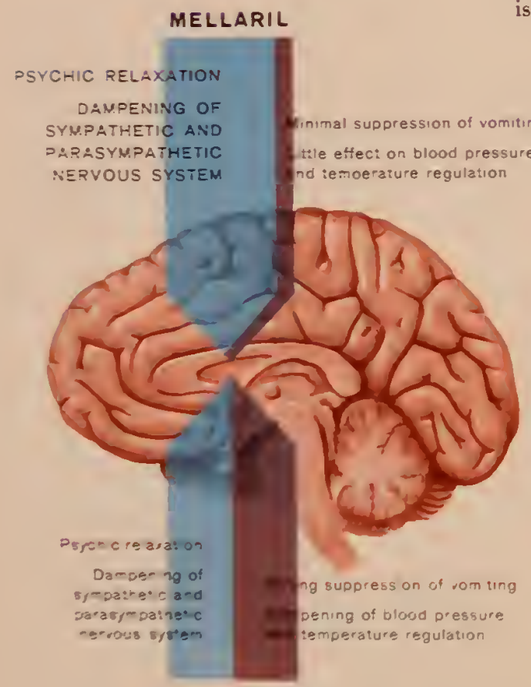
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tranquilization anti-emetic

a new advance in tranquilization:
greater specificity of tranquilizing action plus fewer side effects

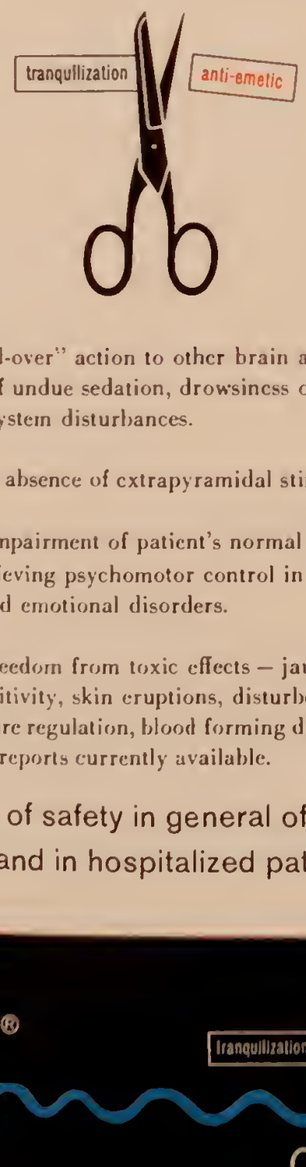


Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical (S-CH3) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



other phenothiazine-type tranquilizers



db

2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD — where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg
MODERATE — where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg
SEVERE — in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg
Hospitalized	100 mg. t.i.d.	200-800 mg
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

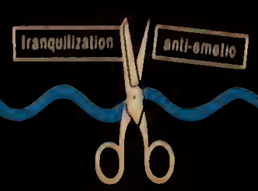
SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association, Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) In Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959.

- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc. because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

SANDOZ

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THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels



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State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

HE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 o underwrite its exclusively recognized group plan of accident and health insurance and officially selected he NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and ealth insurance. Applications are invited from Soci-ty members who have not as yet applied; policies are vailable to applicants in accordance with Company rules and regulations for acceptance of risks.

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NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

CCIDENTAL BODILY NJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

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(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

ONDITIONS OF ENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

XCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.

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Kasdon, S. C., Morentin, B. O.: J. Internat. Coll. Surgeons 31:455 (Apr.) 1959.

...time and time again, gentle, natural acting 'Senokot' is cited in clinical reports as the therapy of choice in all patients with acute or chronic constipation.

'Senokot' acts uniquely, through neuro-stimulation of Auerbach's plexus in the colon, duplicating the process of normal defecation.

When therapy with 'Senokot' is substituted for enemas the difference is safe, natural physiologic correction of constipation, and increased patient comfort, as well as significant saving of time for your hospital's nursing staff.

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Small and easy to swallow, in bottles of 100.

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Cocoa-flavored, in 8 and 4 ounce canisters.

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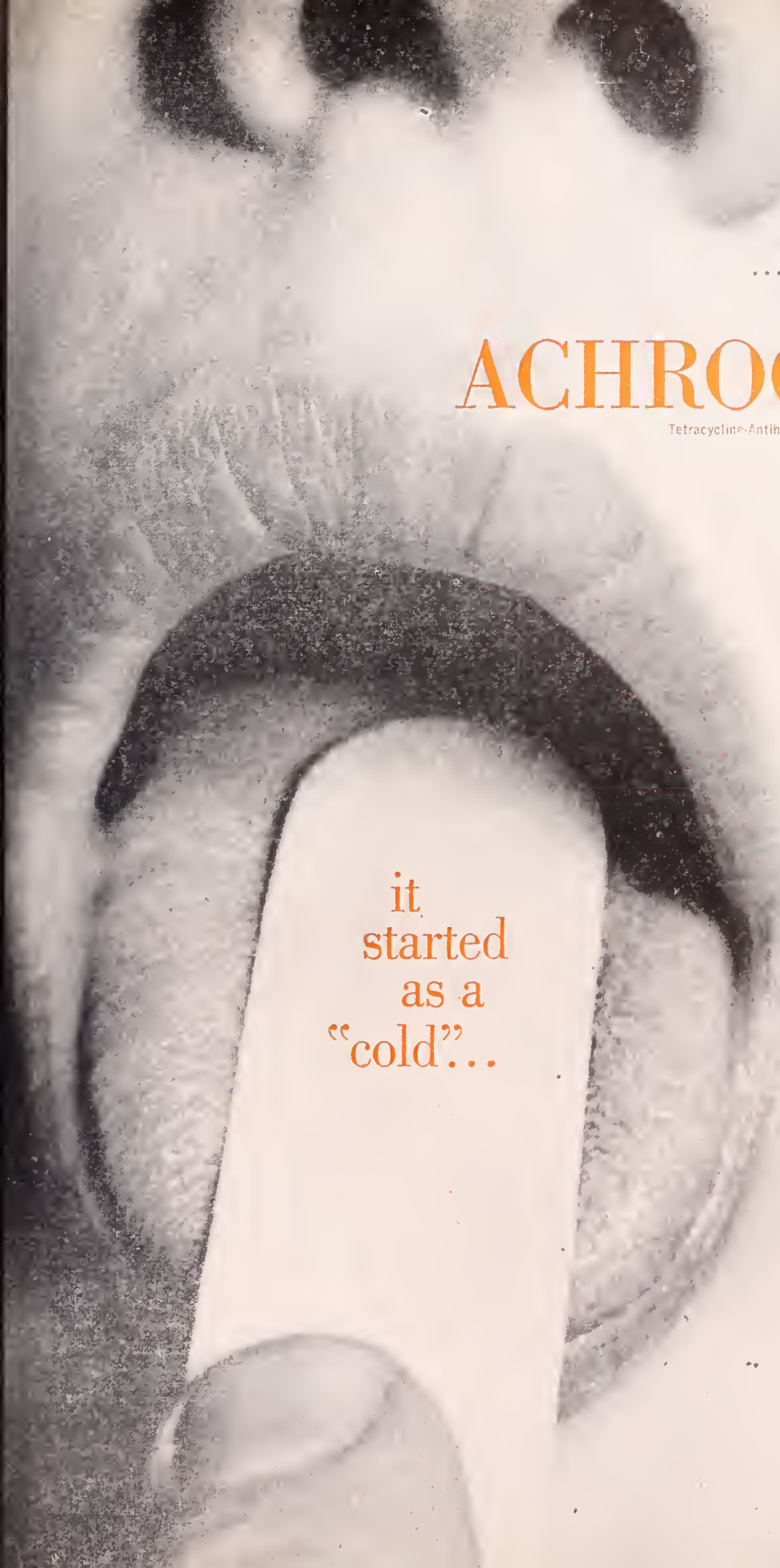
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it started as a "cold"...

to prevent the sequelae of u.r.i. ...and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

Lederle

LEDERLE LABORATORIES,
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Effective relief in rheumatic disorders

Sterazolidin® capsules

prednisone-phenylbutazone Geigy

Geigy

with less risk of disturbing hormonal balance



In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

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Sterazolidin® (prednisone-phenylbutazone Geigy). Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg. and homatropine methylbromide 1.25 mg.

1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

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There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the efficacy, potency and purity of Bayer Aspirin, the world's first aspirin.

And the same manufacturing skill, the same 106 ingredient and product tests, the same exclusive processes which contribute to the superiority of Bayer Aspirin set the standards of excellence for Bayer Aspirin for Children.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

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NO SALT ..but seasone



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An excellent salt replacement
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Contains potassium chlori potassium glutamate, glutamic acid, calcium silicate, potassium iodide (0.01%).

2 oz. shakers and
8 oz. bottles

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Winthrop LABORATORIES
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Assures patient's cooperation



for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

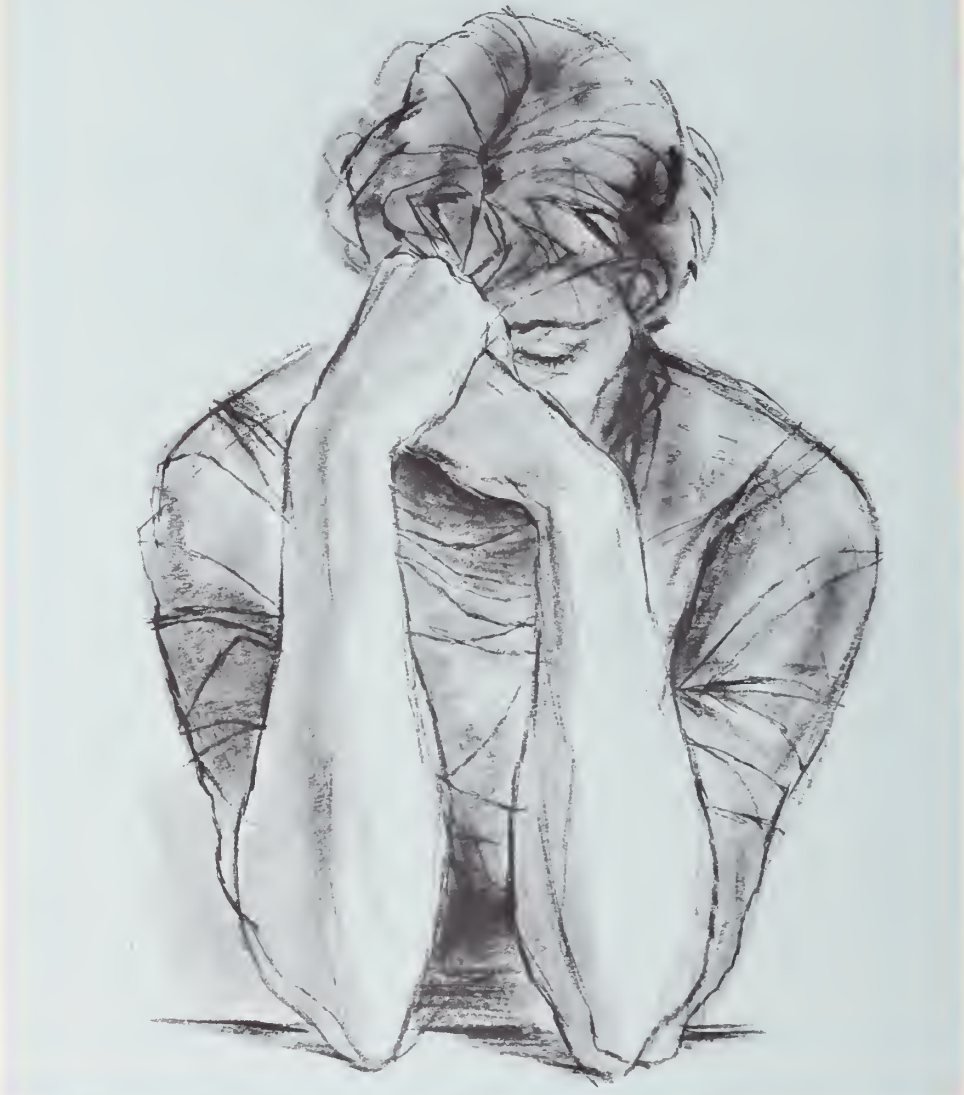
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A survey of 1000 women revealed that *psychic and psychosomatic factors* are responsible for most symptoms of premenstrual tension.

In a one-year placebo-controlled study,[1] Miltown

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- was found "an [excellent] drug for repeated use, as in premenstrual tension."

Miltown causes no adverse effects on circulatory system, G. I. tract, respiration, mental faculties, motor control or normal behavior.

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1. Pennington, V. M.: Meprobamate (Miltown) in premenstrual tension. J.A.M.A. 164:638, June 8, 1957.

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Now —All cold symptoms can be controlled



Tussagesic

timed-release tablets

Controls congestion
with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever
with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

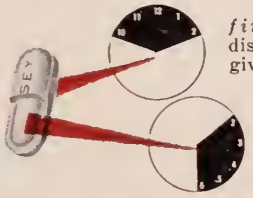
TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.
pheniramine maleate	12.5 mg.
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

Controls cough centrally
with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,[6] as effective as codeine.

Liquefies tenacious mucus
with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first — the outer layer dissolves within minutes to give 3 to 4 hours of relief

then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

Pertinent information for doctors about

KENT'S SUPER-POROUS MICROPORE PAPER

With the intensive publicity being given to porous cigarette paper in recent weeks, Kent believes that doctors would be interested in knowing the scientific facts about the paper used in today's Kent cigarettes.

Kent's exclusive super-porous Micropore paper lets cool air in, lets heat escape through microscopic pores in the paper. The increased oxygen in the tobacco cylinder brings about more complete combustion of the tobaccos. As a result, Kent smokers have been getting a cooler, cleaner, fresher taste in smoking.

When the advantages of Kent's Micropore paper are coupled to Kent's other superiorities, it is easy to understand why more people, during the past year, changed to Kent than to any other cigarette in America.

Kent smokers also enjoy a free and easy draw, which brings through the rich taste of Kent's costly blend of 100% natural tobaccos. In addition, Kent's exclusive Micronite Filter has made a significant contribution in the area of filtration: Kent has reduced tars and nicotine to the lowest level among all leading brands.



The American smoking public was quick to respond to Kent. They discovered—it makes good sense to smoke Kent, and good smoking, too.

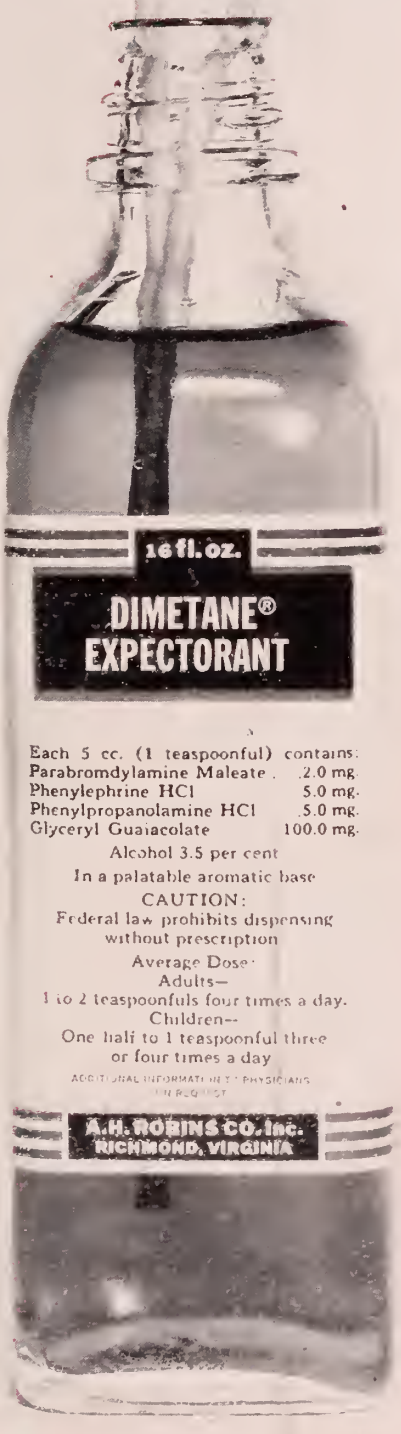
If you would like for your own use the booklet, "The Story of Kent," write to:
P. Lorillard Company
Research Department
200 East 42nd Street
New York 17, N.Y.

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A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

new for cough



tastes good

straws just symbol-
the good flavor! And
ETANE EXPECTORANT
cough is as effec-
e as it is delicious.
MULA: each 5 cc. (1
spoonful) contains:
IETANE (Parabrom-
mine Maleate) 2.0
; Glyceryl Guaiaco-
e 100.0 mg.; Phenyl-
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oride, NNR 5.0 mg.;
ohol 3.5% in a good-
ting aromatic base.

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combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceryl guaiacolate (which increases R.T.E almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic).

)imetane® Expectorant

Robins

)imetane® Expectorant-DC

NIAMID*

the mood brightener

Lifts the burden of depression... opens the way for a sunnier outlook

New areas of therapy

NIAMID is clinically effective in a broad
depressive states, including: involution
cholia, senile depression, postpartum d
reactive depression, the depressive stage
depressive disease, and schizophrenic
reaction.

A wide variety of psychoneurotic depre
in general practice also respond effe
NIAMID. Depression associated with the n
and with postoperative states, and depr
companying chronic or incurable disease
gastrointestinal and cardiovascular dis
thritis, and inoperable cancer, can now
successfully with NIAMID.

NIAMID is also strikingly effective for m
plaints, mild or severe, vague or well defi
due to masked depression rather than
disease. This masked depression may take
of guilt feelings, crying spells or sadness
in concentration, loss of energy or drive,
emotional fatigue, feelings of hopelessne
lessness, loss of interest in normal activit
ness, apprehension or agitation, and loss
and weight.

While tranquilizers have had some m
effectiveness in many of these areas, NI
gives the practicing physician a new, saf
the specific treatment of depression w
risk of increasing the depressive sympt

New safety

NIAMID, in extensive clinical trials, has
associated with the hepatotoxic reactions
with the first of the monoamine oxidase i
These reactions have not been seen with

Acute and chronic toxicity studies show
tinctive freedom from toxicity. Moreov
the extensive clinical trials of NIAMID b
number of investigators, not only has no l
age been reported, but only in a very fe
instances have hypotensive effects been s

The absence of toxicity may be the res
unique carboxamide group in the NIAMID
This structure may explain why NIAMID
largely unchanged in the urine, with only
cant quantities of potentially free hydraz
formed. Previously, where a monoamin
inhibitor had been associated with hepati
there was some evidence that substantial
of free hydrazine were formed in the bod

Background of NIAMID

A major advance in the treatment of m
pression came with a newer understandi
influence of brain serotonin and norepine
the mood. Levels of both these neuro-hor
decreased in animals under experiment
tions analogous to depression; relief of th
depressions is seen with a rise in the leve
serotonin and norepinephrine.

A second advance came with the develo
monoamine oxidase inhibitors, substanc
raise the cerebral level of both serotonin
epinephrine. The first of the amine oxida
tors raised the cerebral level of serotonin
not appear to raise that of norepinephr
proportionately.

Pfizer *Science for the world's well-bein*

PFIZER LABORATORIES

Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y

*TRADEMARK FOR BRAND OF NIALAMIDE



Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

*TRADEMARK FOR BRAND OF NIALAMIDE

NIAMID
the mood brightener



WHENEVER COUGH THERAPY IS INDICATED

Hycomine SYRUP

THE *complete* Rx FOR COUGH CONTROL

cough sedative / antihistamine / expectorant

- relieves cough and associated symptoms in 15-20 minutes
- effective for 6 hours or longer
- promotes expectoration
- rarely constipates
- agreeably cherry-flavored

Each teaspoonful (5 cc.) contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Supplied: As a pleasant-to-take syrup. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

U.S. Pat. 2,630,400

For arthritic M.S.: full corticosteroid benefits from new Gammacorten™



Patient M.S., 81, at the time of the first visit was in severe pain and very uncomfortable. Complained of swelling of wrists, legs and various joints; pain and stiffness in cervical area and lower spine; pain, swelling and limited motion in the fingers; slight ulnar deviation of the hand. M.S. demonstrates position necessary to put on his hat (motion was so restricted that he could not comb his hair).

Treatment and Result: After 36 hours of GAMMACORTEN therapy, M.S. had "complete relief." Joint swelling had decreased, pain was almost absent, range of motion had increased dramatically. At the end of the first week of GAMMACORTEN he was free of discomfort and able to return to his job as a porter. M.S. could put on his hat normally, could comb hair; joint function near-normal after first week.

Gammacorten™

(dexamethasone CIBA)

- potent, effective corticosteroid
- profound anti-inflammatory activity
- minimal side effects

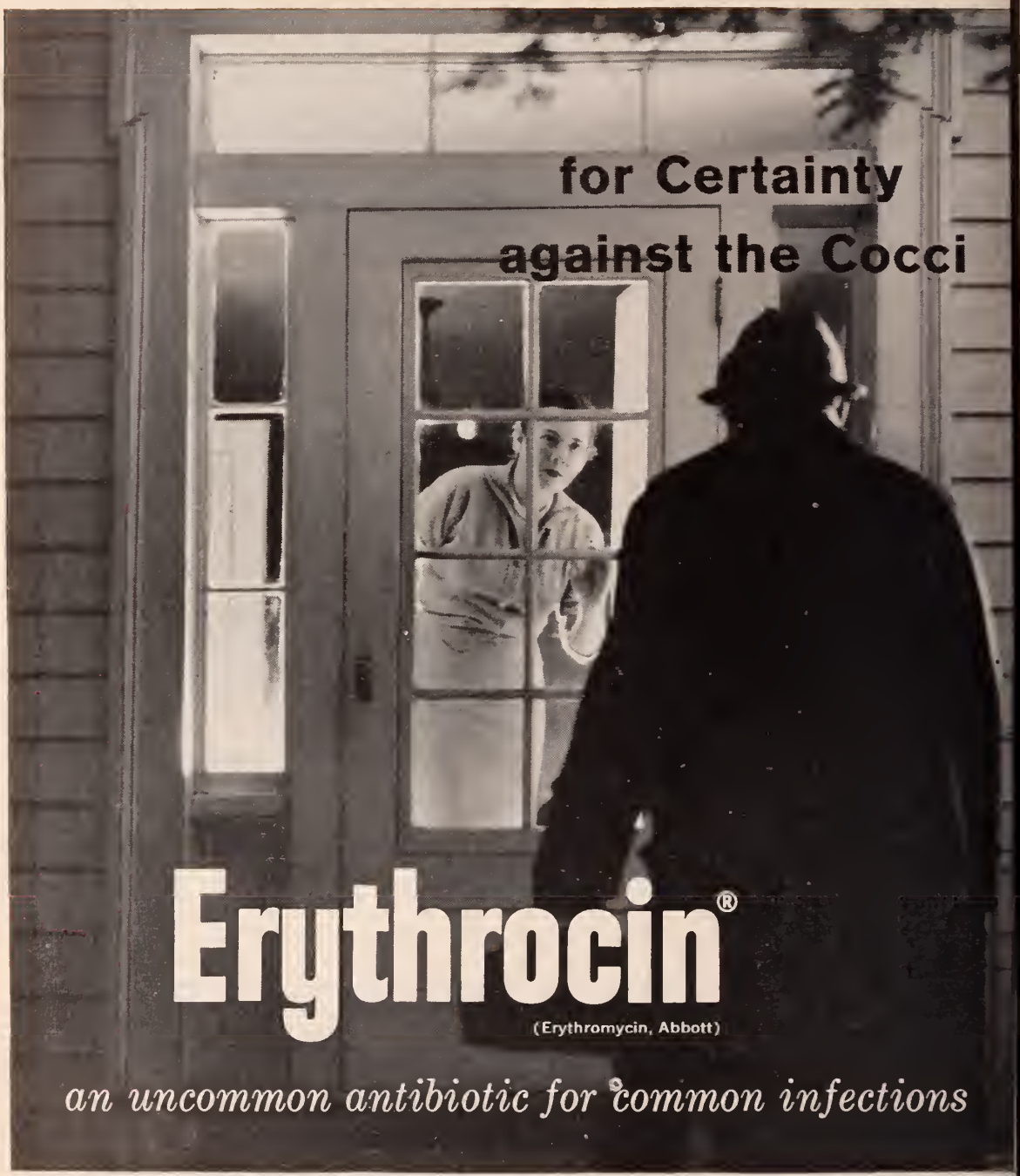
From the files of a practicing physician. Photographs used with permission of the patient.

SUPPLIED: GAMMACORTEN Tablets, 0.75 mg. (pink, scored).



CIBA
SUMMIT, N. J.

2/2723MK



Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs® (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.

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In the menopause...
transition without tears



Milprem promptly relieves emotional distress with lasting control of physical symptoms

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Miltown®+conjugated estrogens (equine)

Supplied in two potencies for dosage flexibility:

MILPREM-400, each coated pink tablet contains 400 mg. Miltown (meprobamate) and 0.4 mg. conjugated estrogens (equine)

MILPREM-200, each coated old-rose tablet contains 200 mg. Miltown and 0.4 mg. conjugated estrogens (equine).

Both potencies in bottles of 60.

Literature and samples on request.

In minutes, Milprem starts to ease anxiety and depression. It relieves insomnia, relaxes tense muscles; alleviates low back pain and tension headache. As the patient continues on Milprem, the replacement of estrogens checks hot flushes and other physical symptoms.

Easy dosage schedule: One Milprem tablet t.i.d. in 21-day courses with one-week rest periods; during the rest periods, Miltown alone can sustain the patient.

WALLACE LABORATORIES, *New Brunswick, N. J.*

CMP-5524-69

new hope for fetal salvage

DEL

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was signif improved. 108 (76%) of 142 babies birth weight survived without mothers ing progestational therapy, while 16 of 16 babies of this birth weight surviv mothers receiving Delalutin therapy. parison study was made of a gr repeated aborters treated with Del and a group with a similar history with bed rest and sedation.[4] Pre salvage with Delalutin was twice that control group. Delalutin was found "highly active", well-tolerated and acting.

According to Tyler and Olson,[5] " qualities of prolonged action and r freedom from local reactions [Delalutin] a generally more des therapeutic agent for intramuscula than progesterone...."

DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL AB



Mary Ann Cribben
Garden City, N. Y.



Amy Sue Greenman
Lincolnwood, Ill.



William Peller
Skokie, Ill.



Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knu
Norwich,

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

improved progestational therapy

UTIN

HYDROPROGESTERONE CAPROATE

LALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

LUTIN is also potent and safe therapy for: threatened abortion; postpartum after-; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated genital malignancy; infertility with inadequate corpus luteum function: production of ory endometrium and desquamation during estrogen therapy; premenstrual tension; norrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

uistration and dosage:

se of its low viscosity, Delalutin may be admin- d with a small gauge needle (deep intragluteal ion). Complete information on administration osage is supplied in the package insert.

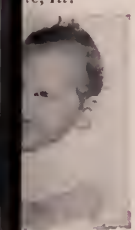
Supply:

Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyproges- terone caproate in sesame oil, and benzyl benzoate.

these healthy, normal babies was born by a mother with a documented previous history abitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



tkowski
le, Ill.



erderosa
, N. Y.



Rosanne Guberman
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Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Zinc Bacitracin ..... 400 Units
Neomycin Sulfate ..... 5 mg.
Hydrocortisone ..... (1%) 10 mg.
in a special petrolatum base.



Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Neomycin Sulfate ..... 5 mg.
Zinc Bacitracin ..... 400 Units
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Each gram contains:
'Aerosporin'® brand
Polymyxin B Sulfate ..... 10,000 Units
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in a special petrolatum base.

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in the depressed, unhappy patient

PROMPTLY IMPROVES MOOD

without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.



EFFICACY AND SAFETY CONFIRMED IN OVER 3,000 DOCUMENTED CASE HISTORIES.[1, 2, 3]

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each light-pink, scored tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

References:
1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

for depression

▲Deprol▲†

®WALLACE LABORATORIES, *New Brunswick, N. J.*

†TRADE-MARK

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tion of FULVICIN (▲)
i ringworm:
ratin penetrated from bloodstream;
ngal growth checked

oral route to ringworm control

new

ulvicin

griseofulvin

lly effective antifungal antibiotic against ringworm

penetration—*first* fungistatic agent to permeate keratin *from the inside*—oral FULVICIN is deposited into dermis, hair and nails—acts to check invading fungi until new, healthy tissue grows out.

effectiveness[1-6]—FULVICIN clears tineas of scalp, body and feet often in 2 to 3 weeks...nails (onychomycosis) usually clear in 3 to 4 months, regardless of previous duration or resistance...promotes rapid relief of itching...prompt loss of hyperkeratosis...rapid fungistasis in infected hair and nails.

safety[1-6]—very low toxicity in therapeutic doses... the few side effects reported (e.g., gastric discomfort, diarrhea and headache) are mild and self-limited.

Rapid clearing of tinea capitis, tinea barbae, tinea corporis, tinea cruris, tinea pedis and onychomycosis caused by Microsporum, Trichophyton and Epidermophyton organisms.

Packaging: FULVICIN is supplied as 250 mg. scored tablets, bottles of 30.

Bibliography: (1) Riehl, G.: Griseofulvin: An Orally Active Antibiotic, presented at Austrian Dermat. Soc. Meet., Vienna, Nov. 27, 1958. (2) Williams, D. I.; Marten, R. H., and Sarkany, I.: Lancet *2*:1212, 1958. (3) Blank, H., and Roth, F. J., Jr.: A.M.A. Arch. Dermat. *79*:259, 1959. (4) Goldfarb, N., and Rosenthal, S. A.: Current M. Digest *26*:67, 1959. (5) Reiss, F.: Medical Circle Bulletin *6*:9, 1959. (6) Robinson, H. M., Jr.; Robinson, R. C. V.; Bereston, E. S.; Manchey, L. L., and Bell, F. K.: Griseofulvin, Clinical and Experimental Studies, presented at Am. Dermat. Assoc. Meet., Atlantic City, N. J., June 3, 1959.

FULVICIN—T.M.—brand of griseofulvin.

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DARVON® COMPOUND potent · safe · well tolerated

The clinical usefulness of Darvon® (dextro propoxyphene hydrochloride, Lilly), alone and in combination, has been substantiated by more than 100 investigators in the treatment of over 6,300 patients in pain. A consolidation of these reports shows that 5,663 (89.8 percent) experienced "effective analgesia."

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Usual dosage: 1 or 2 Pulvules three or four times daily.

Also available: Darvon, in 32 and 65-mg. Pulvules.

Usual dosage: 32 mg. (approximately 1/2 grain) every four hours or 65 mg. (1 grain) every six hours.

Darvon® Compound (dextro propoxyphene and acetylsalicylic acid compound, Lilly)

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Unintended Guinea Pig

Without bold experimentation, the march of medicine would come to a halt. Some experimentation, particularly in pharmacology and surgery, may be conducted adequately on lower animals first. Even there, however, there must at some point, be a courageous willingness to experiment on a human being. There are other experimental procedures, particularly in the behavior sciences, which are not satisfactorily conducted on lower animals.

The history of human volunteers in medical research is a long and honorable one. Many doctors and nurses have courageously permitted experimentation on themselves and many people in all walks of life have volunteered to serve as human guinea pigs for the advancement of medical science.

However, the average man and woman cannot be asked to volunteer. If he is one, he should accept this accolade with a full knowledge of the risks involved. While it may not be illegal, it is certainly morally questionable to experiment on a human subject without letting him know that this is an experimental procedure.

The clinician may in effect, be using his patients as experimental animals if he gives them free samples of brand new drugs, the safety of which has not been supported by previous scientific studies. The practitioner can be talked into becoming an investigator for the manufacturer without quite realizing it. The representative of the drug company tells the doctor about this new product which puts the patient gently to sleep at night and wakes him brilliantly in the morning. He does not cite any supporting evidence apart from a few personal communications from people unknown to the doctor. He may mention that some experimental work is now underway in a famous university or clinic. But he does not cite documentary support to show that this work has so far confirmed the boasts of the manufacturer.

He hands the doctor some literature which indicates that the new drug is very fine, in-

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deed, and then says: "Before you prescribe it, why not actually try it out on your own patients? After all, doctor, what really counts is what you think of it in actual practice and not what we claim."

This sounds pretty good. The doctor accepts the samples. The next few patients who come in are then told how to take it. The doctor feels that he has saved the patient the expense of paying for a new medicine which might be very costly. He has given his patients the benefit of the most modern drugs without requiring him to dip deep into his pocketbook. Perhaps he does not realize th the safety of the drug has not been exper mentally demonstrated by objective, reputab and disinterested authorities.

The doctor has acted in good faith. Usual no harm is done. Reputable drug houses d not prematurely release drugs while there any question about their safety. However, a this point in the development of the new dru it is frankly experimental. Every practitione has a moral responsibility to see to it that th patient is fully apprised of the provisional na ture of the treatment.

The Fading Imagery of Medical Words

Miliary tuberculosis, the professor told us back in 1925, is so called because the tubercles were the size of millet seeds. This was supposed to give us the picture. Half of us were country boys who knew that millet was a grass called *Panicum milleaceum*. But the city lads had never handled millet seeds. So our picture of millet seeds came from inspection of the tubercles, not *vice versa*. Then there was water-hammer pulse. This was intended to be a very vivid description of Corrigan's pulse—but most of us had never seen, felt or heard a water-hammer in operation. And the wine press of Herophilus! Wonderful anatomic imagery here, provided you had seen a wine-press yourself. In those days we did know what horse shoes looked like so we could picture a horseshoe kidney. But today's medical student (homo urbaniensis) has never actually seen a real functioning horseshoe; so he has to get the picture from good luck floral wreaths. Then there is that folded fundus gall bladder still called a "Phrygian cap." Know where Phrygia is and what kind of caps the natives wore?

Our pathologist didn't like to refer to amyloid degeneration. He preferred to call it "sago spleen" because, he said, it was such an accurate pictorial image of what the spleen looked like.

But how did we city slickers and suburban residents know what sago looked like? Th dictionary says it's the pith of the *Metroxylo rumphii*, but what's that? The kind of voca resonance known as egophony is not, as yo might suspect, the sound (phoney) of an ego ist (ego), but rather is the bleating of a goa (Greek *Aigos*, goat). Fine, but today's medi cal students never hear goats bleating. Th duckbill speculum is named for a small aquati mammal (*Ornithorhynchus Anatinus*, as every body knows) but where is the model fro which to get the picture? The little stapes, yo know perfectly well, is so-called because it i shaped like a stirrup. But most of us subur banites can visualize a stirrup only by firs recalling what the stapes looks like. To th 18th century gentleman, saber shin was a won derful description of the luetic tibia—but wha doctor in the mid 20th century can tell a sabe from a scimitar?

Cracked pot resonance is a beautiful phrase but where in the modern household can on find a cracked pot on which to get the orig inal sound? Who remembers now what th railroads have to do with railroad spine? A relic, too, of a simple age is housemaid's knee a type of bursitis now more common among the chatelaines themselves than among thei scarce domestic assistants. And chimney sweep's disease: are there any more chimney sweeps in business? Who knows enough about

saddles to recognize a saddle joint? Would our youngest ophthalmologists today know what is meant by "trolley-eye"?*

Naming diseases for occupation may not be scientific, but it makes for a colorful terminology. In addition to housemaid's knee, trolley-eye, chimney-sweep's disease, we have—or used to have—miner's nystagmus, hatter's paralysis, diver's palsy, bricklayers' itch, writers' cramp, painter's colic and soldier's heart. And how about such image-provoking labels as coffin joint, cobblestone tongue (what does the development-dweller know of cobblestones today?), black-water fever, mossy foot, rake teeth and *mal de coit?* As for the latter, worry not: it occurs only in horses and donkeys and the scientific name is dourine.

Two centuries ago an imaginative anatomist found a name for that hollow on the radial side of the wrist produced when you abducted the thumb. It was the *anatomical snuff box* for in those days every educated man knew what a snuff box looked like. But you—when have you last seen a snuff box?

Medical knowledge now is tough to come by. Our field of vision probes deeper so it must get narrower. No longer can we roam all over the periphery of life, calling ourselves "natural philosophers" and taking our terminology from all the nooks and crannies of the world of scholarship. Our vocabulary, like the operating room, is becoming a model of sterility.

*It's like this. Once when your father was a little boy there was a vehicle called "trolley-car." The operator wielded a brass handle. Bits of brass dust would get on his moist finger-tips. When he rubbed his eyes, he might get a conjunctivitis. But doesn't trolley-eye sound much more interesting than conjunctivitis?

Medical Teaching to Lawyers

Elsewhere in this issue, there is announced a course in medicine for attorneys given by the Institute for Practicing Lawyers. The physician lecturers are members of this Society who are making this contribution towards better rapprochement between the two professions. This is a good thing. Medicine and the bar are, together with the clergy, the three basic humanistic professions. Much attention is paid now to disagreements with our legal brethren—for these disagreements make news. Sometimes we don't like to testify in court because lawyers seem so vague about timing. We have all had the experience of endless waits in court rooms—or in corridors outside court room doors. We have wondered why lawyers can't run their court room dockets as smoothly as we run operating room schedules. Sometimes a cross-examination impairs our dignity. Sometimes we become furious at the attorney's obsessional concern with "whereas" and "aforesaid."

But the dispute is a bilateral one. There are things about us that lawyers don't like. They think we are too reluctant to testify, and by this reluctance we throw sand in the machinery of justice. And they have other complaints too—based largely on unfamiliarity with medical concepts. Here is where this fall's course will make its greatest contribution. As indicated on page 580, it will cover many aspects of our common problem. And maybe some day, the lawyers will organize a course for us so that we may see their problems too. Our two professions have so honorable a heritage of public service, that it is proper that, from time to time, we join together and exchange ideas.

ROSWELL K. BROWN, M.D.

Buffalo, New York

Inguinal Hernia*

Here, in a few pages, is a veritable textbook of hernia surgery—a ready reference guide to a most satisfactory operative procedure.

REPAIR of inguinal hernia is one of the surgeon's most useful procedures. Herniotomy was practiced in antiquity as an emergency treatment of strangulation or obstruction. Not until the latter part of the last century did elective hernia operations become worthwhile.

This presentation includes a series of direct quotations from historic papers on hernia, a short discussion of etiology and a description of the essential technics of the modern operation.

HISTORY

IN 1879 Marcy[1] wrote: "In comparing the operation with that usually recommended of subcutaneously stitching the ring with sutures of any material, it seems apparent that to cut down and expose the ring gives much better opportunity of carefully closing it, and thus avoids injury to the spermatic cord, while it does not increase the danger of the patient."

Apparently he was referring to the subcutaneous inguinal ring.

In 1887 Bassini[2] wrote that "he divides the aponeurosis of external oblique from the external inguinal ring to a point past the internal ring and completely separates the spermatic cord from the neck of the hernia sac . . . up to where the neck joins the peritoneum. Here he places a ligature or suture of catgut and excises the sac distally. The ligated or sutured peritoneum (sac) retracts as it is cut off into the internal iliac fossa. He removes part or all of the sac according to its origin, congenital or acquired. . . . This technic should reconstruct the inguinal canal physiologically, *i.e.*, made up of two openings, one abdominal and one subcutaneous; and two walls, one posterior and one anterior and in between them the spermatic cord passes obliquely."

From this it is clear that Bassini's great contribution consisted of opening the inguinal canal and treating the hernia sac at its origin, the deep inguinal ring. In this sense, all modern hernia operations are Bassini operations. This should not be obscured by details of the reconstruction (Figure 1).

Two years later, in 1889, Halsted[3] described his operation for inguinal hernia as follows.

*From the Department of Surgery, University of Buffalo, School of Medicine. This paper was read, by invitation, before the Section on Surgery at the Annual Meeting of The Medical Society of New Jersey in Atlantic City on April 28, 1959.

1. Marcy, H. O.: The Radical Cure of Hernia by the Use of the Carbolized Catgut Ligature. Transactions of the American Medical Association 29:295 (1878).

2. Bassini, E.: Societa' Italiana di Chirurgia, 4:380 (1887). Nuova tecnica per la cura delle ernie inguinali. English translation by Giovanni Galletti, M.D., page 10 of the Bulletin of the Buffalo Academy of Medicine, Erie County Medical Bulletin, September 1958.

3. Halsted, W. S.: The Radical Cure of Hernia *Johns Hopkins Hospital Bulletin*, No. 1:12 (December 1889).

"(1) Throughout the entire length of the incision everything superficial to the peritoneum is cut through. (2) The vas deferens with its vessels is carefully isolated up to the outer termination of the incision and held aside. (3) The sac is opened and dissected from the tissues which envelope it. (4) The abdominal cavity is closed with quilted sutures passed through the peritoneum at a level higher by ½ to 2 inches than that of the so-called neck of the sac. (5) The vas deferens and its vessels are transplanted to the upper outer angle of the wound. (6) Interrupted, strong silk sutures passed so as to include everything between the skin and the peritoneum are used to close the deeper portion of the wound which is sewed from the crest of the pubes to the upper outer angle of the incision. The cord now lies superficial to these structures and emerges through the abdominal muscles about one inch to the inner side of the anterior superior spine of the ilium. (7) The skin is united over the cord by interrupted stitches of very fine silk. These stitches do not perforate the skin, and when tied they become buried. They are taken from the under side of the skin and made to include only its deep layers—the layers which are not occupied by sebaceous follicles."

This subcuticular closure of the skin is the only part of the Halsted operation which is recommended. This excellent, clear description of Halsted's operation is in marked contrast to Bassini's concept of the desirability of maintaining or restoring the obliquity of the inguinal canal.

In 1890 Bull[4] reported dissatisfaction with the current methods of dealing with inguinal hernia: Heaton's injection method, Riesel's ligature of the sac at its highest point, Czerny's "Closure of the pillars of the external ring with sutures;" Socin's "Merely leaving the canal to granulate over the sutured integuments." He apparently did not know of Bassini's contribution. His description of the operation was: "After exposure of the neck of the sac, by dividing the integuments and anterior wall of the inguinal canal, the sac was isolated and ligated at its neck with catgut; the portion below was dissected out when it was small; when large containing the testicle, it was merely drained through the bottom of the scrotum. The wound was sutured over a drain in the inguinal canal, which was left for 3 or 4 days. This method . . . may for brevity, be termed the method of ligature and excision of the sac."

McArthur[5] in 1901 published his account of the use of the "Auto-plastic sutures in hernia and other diastases." He used the external oblique aponeurosis as a living fascial suture leaving it attached to the pubis, weaving it back and forth.

In 1939 McVay[6] published his important contribution, "A Fundamental Error in the Bassini Operation for Direct Inguinal Hernia."

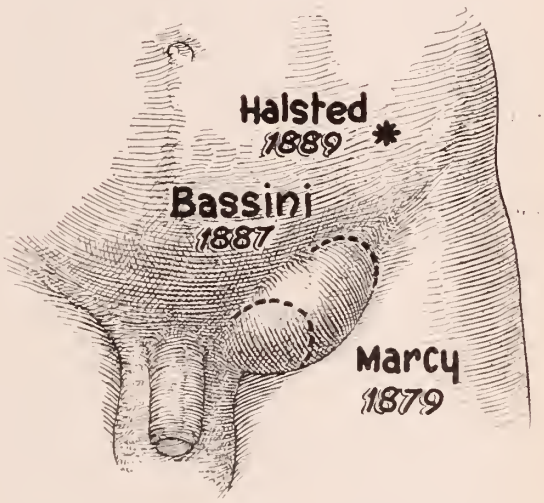


Figure 1—Level of hernia repair: Marcy[1] at the subcutaneous ring, Bassini[2] at the deep ring, Halsted[3] "one inch to the inner side of the anterior superior spine of the ileum."

The McVay operation[7] consists of suturing the rectus sheath and more laterally the transversalis fascia (aponeurosis) to the superior pubis (Cooper's) ligament and more laterally to the femoral sheath. He uses a longitudinal relaxing incision in the rectus sheath over the lower part of the rectus and the pyramidalis muscles.

4. Bull, W. T.: Transactions of the American Surgical Association, 9:99 (1890).

5. McArthur, L. L.: Journal of the American Medical Association, 37:1162 (Dec. 1901).

6. McVay, C. B.: A Fundamental Error in the Bassini Operation for Direct Inguinal Hernia, University Hospital Bulletin, Ann Arbor, 5:14 (1939).

7. Idem. Inguinal and Femoral Hernioplasty. Annals of Surgery, 148:499 (June 1958).

ETIOLOGY

In view of the enormous literature on hernia it is strange there is so little useful knowledge about the causation. Premature birth predisposes to the presentation of inguinal hernias. Because some of these disappear spontaneously, one should avoid, if possible, hernia operations in premature infants till they are at least as old as a full term nine months newborn. However, if there are periods of strangulation or if the hernia is increasing greatly in size, operation should be undertaken promptly. The structures of a premature infant are delicate and the dissection requires finesse but the results are good and the risk is extremely small.

Abnormal increases in intra-abdominal pressure are important in the initiation of symptoms: coughing, straining to empty hollow pelvic viscera, strenuous muscular efforts such as occur during the course of pneumonia, constipation, prostatism and heavy work. Attention to these causative factors should be given both before and after operation to reduce the danger of recurrence.

During 1955 and 1956 the author operated upon 91 inguinal hernias in 76 patients, 55 infants and children, and 21 adults. The youngest at operation was a premature infant 9 days old and the oldest was a man of 71. The following four observations seem relevant:

(a) There was no surgical mortality.

(b) Only one recurrence was found in a 2 to 4 year follow-up. Only 6 did not return for examination; 5 of these stated that the result was good.

(c) Testicular atrophy did not occur. The testes were evaluated on the basis of size, shape, position, consistency and mobility.

(d) Only 4 of 56 unilateral herniorrhaphy cases showed any evidence of contralateral hernias within the 2 to 4 year period of observation.

ESSENTIALS OF OPERATION

The essentials of the modern hernia operation are: (1) high ligation and ablation of the sac, (2) examination of the area for other hernias from within, and (3) maintenance or restoration of the natural obliquity of the inguinal canal. The first and third essentials were adequately stressed by Bassini. With respect to examination for other hernias, Bassini [2] says that "when the patient is stimulated to vomit after this last stage, the triple musculo-aponeurotic layer fixed to Poupart's ligament is tense and well fixed in position and capable of resisting the greatest intra-abdominal pressure."

The cooperation of the anesthesist in having the patient strain after closure of the posterior wall of the inguinal canal is a technic we all know and which we should, perhaps, use more often.

When the sac is open an examining finger should be inserted and the adjacent areas palpated for co-existing hernias, not forgetting the femoral area and the opposite groin.

There is a tendency nowadays to advocate bilateral operations on a suspicion of hernia on the second side. We believe that operation is indicated only in the presence of *definite* evidence of hernia. The peritoneal dimple at the deep inguinal ring of the opposite side can easily be palpated at operation through the peritoneal cavity by the operator's finger in some children. In infants and adults, transperitoneal instrumentation may give considerable information. For this purpose we use bendable bile duct probes and dilators.

In children and young adults examination of the site of direct inguinal hernia through the indirect inguinal hernia sac almost invariably demonstrates a firm abdominal wall medial to the deep epigastric vessels, *i.e.*, no direct inguinal hernia bulge exists. Under these circumstances no reconstruction of the posterior wall of the inguinal canal is undertaken. The operation consists simply of high ligation and oblation of the sac and closure of the external oblique aponeurosis. In the vast majority of indirect inguinal hernias in adults there is also a bulge in the direct hernia area in our experience. The examination from within serves as the basis for the surgeon's plan of repair.

When an indirect inguinal hernia exists for a long time it enlarges the inguinal canal and

stretches the deep inguinal ring downwards and medially and the subcutaneous inguinal ring upwards and laterally, thus shortening the inguinal canal, lessening the obliquity of the cord. The reconstruction should restore the obliquity by displacing the deep inguinal ring upwards and outwards, and the subcutaneous ring medially.

THE superior pubic (Cooper's) ligament is exposed by sharp and blunt dissection. The direct hernia bulge is inverted with sutures of a whip-over or purse-string type in the properitoneal fascia in order to hold it out of the way. The lower margin of the transversus aponeurosis is identified and sutured downwards and backwards to the medial end of the superior pubic (Cooper's) ligament (Figure 2). The so-called conjoined tendon is firmly sutured to the medial end of the superior pubic (Cooper's) ligament and the lateral portion of the transversus aponeurosis is sutured partly to Cooper's and partly to the lacunar (Gimbernat's) ligament and sometimes even to the inguinal (Poupart's) ligament more laterally. This differs from the technic described by McVay [6] in which the femoral sheath is used. We believe that the essential point in closing the gap between the pelvic ligamentous structures and the lower margins of the flat muscles of the abdominal wall consists in bringing the transversus aponeurosis not only downwards but also medially and backwards to the superior pubic (Cooper's) ligament. These sutures are under some tension. We usually use a heavy cotton suture material and place it as a "whip-over" stitch with two bites on either side, the so-called near and far and far and near stitch of Whipple. This is quite different from a mattress stitch, which has the same number of needle bites but which has only two strands of suture material bridging the gap. This stitch has four strands across the gap; it approximates tissues gently but firmly. The four bites of the suture adjust nicely to tissue tensions, twice as many sites for adjustment as are present in the ordinary interrupted stitch. This combines the advantages of the interrupted and the continuous suture.

We almost never cut the rectus sheath in order to allow relaxation for closure. It is not necessary to carry the suturing of the transversus aponeurosis or the conjoined tendon far back on Cooper's ligament, only enough to close the gap. The structures are firm medially, but quite elastic laterally. One closes the gap by suturing the transversus aponeurosis downwards and backwards and medially to Cooper's ligament with the suture bites in the aponeurosis placed more lateral than the bites in Cooper's ligament because it is the fleshy part of the muscle that allows slack for the closure (Figure 2). This simply inserts the muscle aponeurosis into the pubis farther posteriorly and farther laterally along the iliopectineal line. One can obtain a firm closure with 10 to 12 ordinary cotton sutures. Fascial suture material for reinforcement can be easily taken from the external oblique aponeurosis by McArthur's method.[5] A narrow strip is preferred from the upper edge of the external oblique aponeurosis, left attached at the pubis, threaded on an ordinary curved round needle and woven back and forth over the previously placed sutures.

The cord is returned to its anatomic position, the anterior wall of the inguinal canal is closed by overlapping the external oblique aponeurosis enough to take up the slack in it. These stitches displace the subcutaneous in-



Figure 2—Stitch bite in transversus aponeurosis is well lateral to the stitch bite in the superior pubic (Cooper's) ligament. The muscle will stretch, the aponeurotic rectus sheath will not stretch.

guinal ring medially, preferably over the pubis or over the lower part of the rectus sheath. Thus the openings in the three layers of the abdominal wall do not overlie each other.

INCARCERATION AND STRANGULATION

SUDDEN incarceration should be treated as a surgical emergency even if the symptoms and signs of bowel obstruction are absent. In infants, acute strangulation obstruction may be spontaneously relieved during preparation for surgery. Immediate operation is no longer mandatory under these circumstances but the patient should be kept in the hospital for early operation. Attempts to reduce a strangulated hernia by taxis or direct pressure of the surgeon's fingers are not wise. Relaxation of a warm bath and gentle pressure by acute flexion and adduction of the thigh may cause the hernia to slip in (Figure 3), but such undependable methods of treatment should not delay surgery. When the external oblique is opened at operation and the deep inguinal ring is stretched the hernia usually slips back suddenly. If the incarcerated bowel slips out of the field of operation and cannot be located through the deep inguinal ring, it is safe to assume that it is intact and viable. When the bowel is gangrenous it does not slip away. One should not waste time and manipulations in useless search for the released loop. We have recently resected a gangrenous loop at the deep inguinal ring of an infant of two months whose strangulation had existed for 24 hours, and in another case of a female infant 3 months of age the strangulated and gangrenous Fallopian tube and ovary. I neither instance was there any difficulty at a in maintaining the necrotic tissues well withi the field at the deep inguinal ring. Had the been viable they might have quickly slippe out of sight.

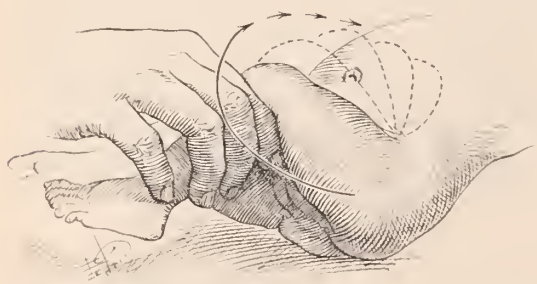


Figure 3—A safe method of attempting to reduce an incarcerated hernia.

OPTIONAL TECHNICS

WE PREFER the skin crease incision which i quite obvious when the skin is folded u in this area. One cannot determine these line of natural skin cleavage from any tables o diagrams, but they can be determined quit easily by careful inspection of the patient Such incisions leave practically no visible ski scar, they are especially appreciated by th parents of our small patients.

We prefer to spread rather than to cut th two layers of the superficial fascia. Thes consist of loose areolar tissue with blood ves sels; they can be easily spread out of the way There is usually no necessity of clamping an ligating more than one of the subcutaneou veins. At the close of the operation the tw layers of superficial fascia are not sutured bu allowed to return to their normal position b the elasticity of the tissues. This technic tend to reduce the amount of foreign body buried as sutures in the subcutaneous tissue and thus lessens the danger of the development o wound complications. The subcutaneous tissue is thoroughly washed out repeatedly with normal saline solution and redundant tabs of fat are removed. The skin is closed with interrupted subcuticular stitches of fine 00 or 000 plain catgut and temporary clamping of Allis clamps. In infants and children the wound is usually covered with collodian without gauze and the infants can then be diapered in the usual way. In older children and adults a small gauze dressing is usually placed over the wound.

WARNINGS

1. Do *not* use manual pressure for closed reduction of a strangulated hernia. Operate at once.

2. Do *not* waste time and operative trauma in searching for the loop of bowel which has slipped out of view. If it retracts away from the groin it is viable.

3. Do *not* leave adjacent direct or femoral hernias undiagnosed and unrepaired. Palpate and probe from within.

4. Do *not* cut or strangulate the vessels of the spermatic cord. *It is better to tear the sac than to tear the cord.*

5. Do not repair the posterior wall of the inguinal canal unless it shows a weakness. Ligate and ablate the sac and close the canal with its normal anatomy.

6. Do *not* try to stretch aponeurosis to close a defect. Stretch muscle.

7. Do *not* suture fleshy muscle fibers. Place the stitches in the aponeurosis or tendon, thereby moving the muscle.

SUMMARY

THE modern hernia operation dates from Bassini's[2] innovation in 1887: opening the inguinal canal, ligating the sac at the deep inguinal ring, and restoring the obliquity of the canal.

Essential and optional details of the operation include features described by Marcy,[1] Bassini,[2] Halsted,[3] Bull,[4] McArthur,[5] and McVay.[6]

A method of suture to the superior pubic ligament without the use of a relaxing incision in the rectus sheath is described.

Results of the operation are excellent in all ages including premature infancy and advanced senility.

596 Delaware Avenue

Warning to Diabetics

Keep Clinitest® Tablets Away From Children

The following timely note comes to us from Dr. Arthur Krosnick, Coordinator of the State Diabetes Control Program.

A case* has been reported of a 3½ year old child who swallowed a Clinitest® tablet and developed an esophageal stricture, which required segmental resection. Four other cases of a similar nature were cited.*

Each Clinitest® tablet contains:

Anhydrous cupric sulfate 0.019 grain
Anhydrous sodium hydroxide 0.25 Gram
Sodium bicarbonate
Citric acid

The anhydrous sodium hydroxide is a strong alkali which produces considerable heat when moistened. This results in a corrosive, penetrating injury to tissues, especially the gastrointestinal tract or the eye.

Clinitest® reagent tablets are clearly labeled "Poison—not for internal use". Despite this, some diabetics carelessly leave such tablets in medicine cabinets with drugs for internal use or within the reach of children. This should be brought to the attention of all New Jersey physicians and diabetic patients and their relatives. The N. J. State Department of Health will distribute warning posters to hospitals, poison control centers and public health facilities.

*Zimmerman, C.: American Journal of Diseases of Children, 97:101 (Jan. 1959).

William C. Conroy, M.D., D.D.S.

Montclair

Emergency Management of Maxillo-Facial Injuries

It is often the lot of the intern or junior resident to do the primary surgery in wounds of the face and jaw. As Dr. Conroy says this initial care "may make or break the patient's chances for full recovery." Here is a handy little vade mecum for the house officer or junior surgeon.

In the surgery of trauma, the competence of the initial medical care can make or break the patient's chances for a full recovery from his accident. This considerable responsibility usually becomes the lot of the recently graduated doctor—frequently during lonely early morning hours when opportunities for consultation are limited. The following fundamental considerations will be helpful in the initial evaluation and treatment of facial injuries.

AIRWAY

Protection of the airway is our first concern in severe injuries of the lower half of the face since posterior displacement of the maxilla and fragmentation of the mandible allow soft tissue collapse on the hypopharynx. This becomes progressively worse as edema develops. If breathing is difficult in the supine position in the presence of fractures of both jaws or a severe mandibular fracture, an elective tracheostomy should be done without delay. As a general rule whenever the necessity of a tracheostomy is considered, it should be done immediately as an orderly procedure rather than put off until an acute emergency develops and the procedure prejudiced by frantic haste and an uncooperative patient. When speed is essential, transoral tracheal intubation should be considered if equipment is available. Hypoxia is the most common cause of restlessness in the injured patient. *No sedation should be given unless an unimpeded airway is assured.* The prone position allows drainage of secretions and clearance of the airway by gravity until a tracheostomy is done.

HEMORRHAGE

Serious bleeding is seldom a problem in civilian facial injuries, although brisk hemorrhage is frequently seen. "Pumpers" in accessible wounds should be clamped, taking care not to damage neighboring tissues. With the clamps in place the face is cleansed with aqueous benzalkonium* or thimerosal.† A lacerated face smeared with blood is a confusing and disturbing problem to the uninitiated house officer, which frequently solves itself with simple cleansing.

Bleeding from the nose may be controlled by packing with hemostatic cellulose or simply

*Available under the Winthrop-Stearns trade-name of Zephiran®.
†Available under the Lilly trade-name of Merthiolate®.

non-adherent gauze. This should be introduced with the aid of a nasal speculum to avoid insertion into the mucosal laceration.

Although persistent bleeding may occur intraorally and intranasally from the facial bone fractures, it usually subsides spontaneously before serious hemoglobin loss occurs. Hemostasis is aided by early immobilization of the fragments. Large quantities of blood may be swallowed and, as with all severe injuries, careful observation of blood pressure and pulse and blood components with preparation for replacement is in order.

HEAD INJURIES

THE light, comparatively fragile facial bones frequently, in breaking, serve as a cushion for the brain against blows from the front. Certain signals warning of intracranial damage should not be ignored. A history of unconsciousness is significant. Postaccident memory deficits are of more serious import than failure to remember details immediately before the accident. Interval examinations with observation of a progressive increase or decrease in the state of consciousness are valuable clues to the intracranial status. Scalp lacerations should be gently explored with the sterile gloved finger for cranial fractures before closing. Cranial fractures, particularly depressed ones, are significant. Such fractures may be accompanied by little intracranial damage. In the absence of other findings of cerebral damage they should not contribute to malunion of facial bone fractures through needless postponement of reduction and fixation. Conversely, an intact skull does not rule out intracranial damage. All head injuries producing unconsciousness or headaches should have skull x-rays. Increased intracranial pressure is evidenced by a progressive deterioration in the state of consciousness or (if conscious) increasing headache, a slowing pulse, increased systolic blood pressure, irregular, dilated pupils which become fixed on the same side as the brain lesion with exaggerated reflexes on the opposite side. Neurosurgical advice should be obtained when any of these findings are present. A lumbar puncture should *not* be done on admission by the inexperienced house officer, and probably not during the first 48 hours for fear of producing a tentorial or cerebellar pressure cone. Since the state of consciousness is an important guide post, no sedation should be given.

FACIAL FRACTURES

THE broken nose is the commonest facial fracture. It is the most easily diagnosed and usually the easiest to treat. Of importance is the close application of underlying mucous membrane and overlying skin, making deformity of the nasal bones or septum readily evident to the eye and palpating finger before edema appears. Such examination is more reliable than the usual x-ray, although the latter, particularly the occlusal view is helpful in assaying the extent of damage. Any nose bleed following trauma to the nose means mucous membrane laceration and disturbance of the skeletal structures to some degree. Displacement of the latter must be corrected if present. Many serious adult nasal deformities follow careless dismissal of a childhood or adolescent nasal injury. Examination consists of applying a topical anesthetic such as 1 per cent tetracaine‡ or 4 per cent cocaine to the mucous membrane, inspecting the septum with a speculum and, when in doubt as to fracture of a nasal bone, placing a closed clamp beneath it intranasally and testing it for mobility against the overlying examining finger. Pinching the septum with thumb and index finger introduced in either nostril demonstrates septal fractures and dislocations from the vomerine groove when present in adults. The simple nasal fracture with deviation and without septal fracture or dislocation may be reduced by placing a clamp intranasally under the depressed nasal bone, disimpacting it by elevation and then moulding the nose to the midline with the fingers. Anesthesia for reduction in the young healthy adult in addition to the topical may be meperidine (Demerol®—

‡We use the Winthrop-Stearns brand tradenamed as Pontocaine®

Winthrop-Stearns) 100 milligrams in 10 cubic centimeters of saline introduced slowly intravenously while reduction is in progress. General anesthesia is preferred when available. Bleeding is controlled by introduction under direct vision of non-adherent half-inch gauze in either nasal passage and an overlying nasal splint is applied when possible.

The fractured jaw is diagnosed by abnormal occlusion, abnormal mobility with irregularity of the dental arch and pain on clenching the jaws at the site or sites of fractures. The demonstration of crepitus is needless and painful. Should a fracture of the mandible be in doubt, grasping the anterior jaw with thumb and forefinger and gingerly pulling forward or wiggling it will elicit pain. X-rays are indicated when fracture is suspected. Mandibular fractures are clearly delineated. Maxillary breaks are less easily seen and transverse and pyramidal fractures of the maxilla are accompanied by a cloudy, blood filled antrum. Osteomyelitis is no longer the serious problem of pre-antibiotic days, still, early reduction and fixation minimizes complications.

Malar bone fractures are of two varieties. In the simple form the zygomatic process may be indented by direct blow thus interfering with the excursion of the underlying mandibular coronoid process, causing some inability to open or close the jaws and a palpable depression in front of the ear. The complex tripod malar fracture is so named because displacement of the malar bone requires fractures of the three buttresses, namely the fronto-malar, maxillo-malar, and zygomatico-malar. The maxillo-malar fracture line usually traverses the floor of the orbit (possible diplopia), the infra-orbital ridge (palpable irregularity), the infra-orbital foramen (anesthesia or half of the upper lip and incisor teeth) and the antrum (nose bleed and cloudy antrum on x-ray).

Emergency management of facial bone fractures includes points outlined under protection of the airway and control of hemorrhage. Sedation is given when general condition permits and the fractured jaw may be supported with a figure eight bandage while awaiting definitive treatment by a more experienced surgeon.

FACIAL LACERATIONS

THERE are no hard and fast rules to repa
of facial lacerations beyond thorough i
spection of the depths of the wound for i
tegrity of important structures and metic
lous removal of foreign bodies prior to clo
ure. Lacerations of the medial half of th
lower eyelid may involve the lacrimal canal
culus; of the pre-auricular area, the faci
nerve; of the cheek, Stensen's duct. When pre
ent, these should be repaired by experience
surgeons. Wounds of the face should first b
gently cleansed with aqueous thimerosal† o
benzalkonium* to permit evaluation. If loca
anesthesia is possible, it is injected preferabl
into the less sensitive raw wound edge. Epin
ephrine potentiates and prolongs the anesthe
sia and will be appreciated by the patient wit
lacerations of any size. Severe facial lacera
tions and those with facial bone fractures wil
require general anesthesia.

Open facial wounds are usually eithe
abraded (brush burns), contused (blunt blow
with rupture of skin) or incised (glass an
knives). Abraded wounds are frequently
grimy and must be thoroughly scrubbed wit
soap and solvents if necessary. The dirt tatoo
resulting from failure to do this is an unfor
givable error. Delay of a few days may re
sult in serious permanent disfigurement. Fa
cial skin has abundant circulation and debride
ment of facial wounds is limited. However,
the contused wound has devitalization of the
edges which on simple closure will crust, pro
ducing a widened scar. When practical, these
edges should be excised at right angles to the
surface before closure.

When cleansing, inspection, anesthesia and
debridement are completed using aseptic tech
nic (gloves); irregular edges of wounds are
interdigitated and anchored with the initial su
tures. Important landmarks such as eyebrows
(not shaved so that they can be lined up cor
rectly), nasal ala and lip vermilion borders
are aligned first. Through and through lacer
ations of the ear, eyelids, nose and lips should
have supervision when done by the inexper
ienced. Deep sutures of 3-0 or 4-0 plain or
chromic catgut are placed in just sufficient
quantity to effect elimination of subcutaneous

dead space. Dead space means hematoma—a defenseless bacterial playground. Traumatic flaps or tongues of tissue, if viable, should be replaced in position, if almost completely avulsed, should be carefully defatted and replaced as a free graft. Small non-vital areas may be sacrificed, provided the wound may be closed without too much tension. A clean wound may be closed with tension and a dirty wound without tension but we cannot close a dirty wound with tension and these must be considered as probably dirty wounds. The purpose of the superficial sutures is to effect a smooth, completely dry, slightly raised line of closure. Inequality of the height of tissue approximated is wrong. We prefer 5-0 and 6-0 silk, others, heavier silk or nylon. Fine nylon is less likely to strangulate tissue but is more difficult to remove. The heart of the matter is meticulous approximation without the slightest tension, not the time of suture removal since strangulation with inevitable railroad tracks can occur in a matter of hours. Following closure, small wounds are compressed for five minutes to insure dryness and hematoma absence, larger wounds for twenty-four hours with elastic bandage. The properly closed unabraded facial wound needs no protection from clothing and heals best when exposed after the initial compression to control bleeding and edema. Sutures are removed at five to six days.

SUMMARY

ANTICIPATION, not desperation, should indicate tracheostomy. Oxygen and its transportation, not sedation, is the therapy of restlessness in the injured. The relative state of consciousness is the window to the injured brain not to be curtained by sedation. Facial bone fractures are easily within reach of the eyes and fingers. Accurate wound closure without tension, not early suture removal, is the key to cosmetic facial scars.

100 Park Street

For Parents of Crippled Children

Practical helps for the parents of crippled children include the 32-page booklet *You Are Not Alone* written by Lawrence J. Linck, formerly executive director of the Easter Seal Society.

The fourth in a series of publications designed to help parents of crippled children, *You are Not Alone* outlines the assistance available through professional persons, voluntary agencies and federal services.

Advances in human welfare, science, medicine and education made in recent years dictated the necessity for *You Are Not Alone*, according to Dean W. Roberts, M.D., executive director of the National Society for Crippled Children.

"In addition to presenting facts, bibliography and a list of voluntary health and welfare agencies who offer help to parents, we have set out in simple language the part medical specialists, paramedical personnel—including all of the therapies—and others of professional skills play in the rehabilitation of the crippled child," Dr. Roberts says.

Other booklets in the parents' series are *Why Did This Have to Happen?* by Earl Schenck Miers, an inspirational "open letter" by a widely known editor and writer who speaks with insight and personal experience of problems faced by those who are crippled; *Your Child's Play* by Grace Langdon, Ph.D., which describes what toys mean and their value in the rehabilitation of those under treatment; and *Toward Understanding Stuttering* by Wendell Johnson, Ph.D., a study that can help parents avoid stuttering in their children and make the wonders of speech a source of strength, joy and wisdom for their child.

Copies of these publications, at 25 cents each, are available from the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Illinois.

Stuart A. Mason, M.D.

Ridgewood

Peptic Ulcer in the Aged

Though commonly thought of as a disorder of the young, peptic ulcer does occur in the elderly and may mislead the doctor who does not think of it. Symptoms and treatment are somewhat different as here outlined by Dr. Mason.

It is generally believed that peptic ulcer is a disorder of youth or middle age. However, it also occurs in elderly people, and as our average age rises, we will see more and more peptic ulcers in the elderly. And if we persist in thinking of it as a disorder of youth, we will miss the diagnosis.

Another problem in peptic ulcer in the aged is the frequency of complications. I report below a case of bleeding duodenal ulcer in an 82-year old woman with good response to medical treatment.

An 82-year old woman was initially seen on December 21, 1957, complaining of anorexia, a feeling of being "full of gas," and intermittent diffuse upper abdominal pain radiating to the scapulae. These symptoms had been present for three weeks. Once the pain was so severe that narcotics were required for relief. Dyspnea was usually present during an acute episode, subsiding when the pain decreased. She had been taking a proprietary phenobarbital-homatropine-papaverine mixture without significant relief.

Initially, physical examination revealed an uncomfortable elderly woman who did not appear acutely ill. All vital signs were normal. There was a small umbilical hernia. The upper abdomen was diffusely tender but there was neither rigidity nor spasm. No abdominal viscera could be palpated.

The blood count and urine were normal. Electrocardiogram disclosed a sinus bradycardia (60 per minute) with left axis deviation and diphasic T waves in V2-4. Chest x-ray revealed a moderately enlarged left ventricle and a tortuous prominent aorta. Scout films of the abdomen showed only osteoarthritis of the spine. A gall bladder series was negative. She was treated with a fat-free diet, antispasmodics and sedatives.

On December 29, she passed a large tarry stool and collapsed. She was admitted to the Hackensack Hospital.

On admission, she was apprehensive. Blood pressure was 80/50. Normally it was 110/80. The pulse was 88 and the temperature 98. There was mild diffuse upper abdominal tenderness. Other findings were as before.

A surgical consultant concurred in conservative treatment. She was given belladonna, phenobarbital, meperidine, intravenous glucose, conjugated estrogens, vitamins and a bland diet. Blood pressure was promptly stabilized at 92/50. Clinically, she seemed improved.

On admission, hemoglobin was 12.8 Grams, the white count was 11,000; the differential count was polymorphonuclears 77 and lymphocytes 23. Hematocrit was 35 per cent. The urine contained a faint trace of acetone and 5 to 8 white cells per high power field. The stool was positive for occult blood. Nonprotein nitrogen was 35 milligrams per cent.

By the next day, hemoglobin was 9.2 Grams and the hematocrit 31. Sedimentation rate was 18 mm. per hour. On December 31, hematocrit was 36; on January 1, 1958, it was 37. Hemoglobin on January 8 was 14.3 Grams and the white count was 8000 with a normal differential. On January 9, the stool was negative for occult blood.

X-ray series on January 3 revealed a marked deformity of the duodenal bulb with considerable narrowing at the waist. No ulcer crater was seen. The impression was that of a long standing ulcer with cicatrization (See illustrations). The remainder of the small bowel was normal. A barium enema (with double contrast study) was normal.

The abdominal discomfort had subsided shortly after admission. The stool rapidly became normal. She remained in bed but turned frequently and moved her lower extremities often. No leg supports were used. She had no evidence of phlebitis.

Her convalescence was uneventful except for a mild upper respiratory infection treated with penicillin. She was discharged on a convalescent ulcer diet and Tr. belladonna. Several days after her return to her home, she went into sudden collapse and died within a few minutes, apparently of a pulmonary embolus. An autopsy was not secured.





It has been suggested that most elderly patients with gastric and duodenal ulceration acquired the condition in their youth. In truth, however, the disease may make its initial appearance in the elderly. Because of this, and since the clinical picture varies somewhat from that presented in younger patients, the physician must be on his guard if he is not to miss cases in the older age group. Branwood and Robertson [1] reported a series of 116 patients over 60 years of age who had frank gastroduodenal hemorrhage of varying severity. Only eight were subjected to surgery, and 108 received medical treatment alone. Overall mortality for the series was 19 per cent regardless of the ultimate diagnosis or the mode of therapy. In this series, the immediate mortality for the chronic gastric ulcer group was 46 per cent as compared with an 8 per cent mortality for chronic duodenal ulcer. The high mortality is attributed to recurrent bleeding. This is more likely to occur with chronic gastric ulcer than with chronic duodenal ulcer. In this series, conservative medical management gave an excellent prognosis in the absence of recurrent bleeding.

A series of 1800 successive admissions for peptic ulcer, between 1941 and 1947, was reported by Rafsky, Weingarten and Krieger.[2] Three hundred seventy-eight of the patients were over the age of 60. Of these, 81 first definitely developed ulcer symptoms after the age of 50. They were all in the 60-to-80 age bracket. Twenty-one were women. Thirty-two had a gastric ulcer (20 men, 12 women); 43 had duodenal ulcer (including 9 women). Six patients had both gastric and duodenal ulcers. There were 28 cases of hemorrhage in the series. None came to surgery. The advisability of keeping the period of bed rest minimal, and the importance of early ambulation as prophylaxis against pulmonary embolization, are stressed. In the series, 13 patients died (16 per cent of the 81 cases). Of 28 patients with hemorrhage, all treated medically, 3 or 11 per cent died. Of 19 cases treated surgically, 7 died—a mortality of 37 per cent.

Elderly patients often react differently to the pain of peptic ulcer than do younger pa-

1. Branwood, A. W. and Robertson, R. F.: Gastro-Duodenal Hemorrhage in the Elderly. Edinburgh Med. J., 61:305 (1954).

2. Rafsky, H. A., Weingarten, M. and Krieger, C. I.: Onset of Peptic Ulcer in the Aged. J.A.M.A., 136:739 (1948).

and have the slowest conduction rate of all. The cutaneous fibers probably transmit protopathic impulses, *i.e.*, pain.

Pruritus is a component of protopathic pain.

The nature of the stimuli necessary to arouse an itching sensation is not fully understood. Any inflammatory or exudative process which exerts outward pressure on the epidermis may cause itching. Drugs, diabetes, jaundice, leukemia, Hodgkin's disease, chronic nephritis may be accompanied by pruritus. Aging, dry or ichthyotic skin may become very pruritic.

THE PATHWAY

Sensory impulses are mediated to the cortex through three sensory neurones. In pruritus, the primary neurone relays the impulse from the end organ in the skin to the spinal cord; the secondary neurone sends its axone, to the thalamus. The third sensory neurone relays the impulse to the somesthetic area of the cortex by way of the thalamic radiation.

Not all sensory impulses which reach the thalamus are relayed to the higher centers of consciousness. Thalamic activity is controlled by the discriminative, selective and inhibitory powers of the cortex.

THE THALAMUS

The thalamus is a primitive receptive center in which sensory impulses give rise to a rudimentary consciousness, a crude awareness of stimuli from the outer world. Thus to the newborn, vague and meaningless lights and shadows, and a cacophony of sounds, constitute the outer world. Pleasure and pain are dim and generalized sensations of comfort and discomfort.

A constant stream of unregulated and unintegrated impulses flow over the sensory pathways from the skin, nose, tongue, eyes and ears to the thalamus; but not all the impulses that call are chosen for admission to the conscious centers. In the thalamus, the impulses are sorted and classified and under normal conditions only those sensations are selected that can be moulded into perceptions suited to one's present need; thus, one familiar face in a sea of faces or one familiar sound or voice in a cacophony of sound, or a medley of voices will be admitted to the sensory cortex, where through the meshwork of association pathways the sensation invokes recognition, past memories, and chains of related thoughts. The stimulus which initiated the crude sensory impulse is now transformed into perception, memory and knowledge.

The epicritic sensations have free ready access to the cortex through the thalamic radiation. Thus, touching the cheek with a wisp of cotton, a light tap of a finger on the shoulder or a sudden five to ten degrees change of temperature in the ambient atmosphere are immediately registered in the conscious centers.

Itch is a protopathic sensation. Protopathic sensibility, along with other purposeless impulses, is relayed to, and expires in, the region of the thalamus; it is like a mountain stream rushing onto the desert and being absorbed by the desert sands.

The thalamus possesses a high threshold for protopathic sensibility. Though the stimulus must be strong to arouse a sensation, once initiated it can become insistent, demanding and peremptory. It may result in a thalamic overflow which breaks through the inhibitory barriers of the cortex, flooding the whole of consciousness.

The pruritus thus produced is intense, diffuse, poorly localized, singularly unpleasant, and extremely difficult to control. It may induce a scratching furor, a bout of "cutaneous insanity"—during which there are not enough hands or fingernails to scratch and gouge and excoriate. This can occur in generalized eczema from any cause, a widespread neurodermatitis, massive exposure to poison ivy, premycotic mycosis fungoides, and other conditions.

The receptive stimulus necessary to elicit a scratch reflex in the spinal animal is specific in nature. The most adequate stimulus is one simulating as closely as possible the condition that would be produced by the movement of an insect on the integument of the animal, such as gently drawing a pencil or finger tip backward and forward among hairs of the flank and shoulders. A pin prick, rough fric-

tion or deep pressure will not elicit the scratch reflex.

The thalamic threshold is determined by the inhibitory influence of the cortex exerted through the cortico-thalamic tract. Normally the constant storms of stimuli which beat down on cutaneous nerve endings die in the thalamus. The threshold fluctuates from time to time, perhaps from minute to minute. It may be lowered voluntarily. Thus if one concentrates on cutaneous sensations, many prickling and tingling sensations will develop about the hair roots in the scalp or uncomfortable sensations of warmth and moisture especially in axillae, groins, scrotum and belt line, and tingling and burning sensations of the palms and soles. These are manifestations of the constant stream of protopathic sensations which normally never reach the sensorium. The thalamic threshold may remain lowered even after the cause of the itch has been removed. Itch may persist for days or even weeks after such conditions as ivy or scabies.

THE scratch reflex is a primitive protective reaction to rid the integument of noxious materials, especially crawling vermin.

Physiologically, itch is an unimportant sensation in the warning system for the overall safety of the organism. The scratch reflex serves no useful purpose in the vast majority of skin diseases, and in most cases the trauma and inflammation produced by scratching does further injury to the skin, prolongs recovery, and, in some diseases, *e.g.*, psoriasis and lichen planus, may cause the extension of the disease. (Kobner Phenomena)

If an individual with itch, no matter what the cause, is questioned directly and specifically about the pleasure of scratching (not the itch itself or the unpleasant after-effects of scratching) the description will vary from soothing, restful, agreeable to wonderful, delightful, heavenly, followed by "but." The "but" refers to the smarting and pain induced by the scratching and which replaces the itch. Pain impulses are prepotent and wash out less urgent stimuli, at least temporarily.

Why then does nature attach so much pleasure to scratching?

The thalamus and corpus striatum represent an ancient sensory and motor cortex, which, in submammalian animals, are centers for sensation, motor activity and complex reflexes. The anterior and medial nuclei of the thalamus form the paleothalamus which was originally the sensory cortex for crude, uncritical protopathic sensation. The lateral nucleus (neothalamus) becomes larger and more fully developed as the phylogenetic scale is ascended and through it finer epicritic sensation has free access to the sensory cortex.

For the protopathic itch sensation, the ancient terminus is the paleothalamus. This, presumably, undergoes some alteration when admitted to the sensory cortex. It is a case of a primitive sensation registering in a newer and infinitely more complex cortex. It seems reasonable to conjecture that the intensity of the sensation is exalted and the origin of the sensation more accurately localized; it is also reasonable to conjecture that the pleasure from the resultant scratching is more intense, more diffuse and more delightful.

Chronic itching tends to become cyclic and paroxysmal, recurring in a rhythmic pattern. The periodicity depends upon, to some degree, the length of time for healing of previous excoriations, worry, fatigue, tensions, emotional upsets, heat, and humidity. In some instances, especially when the pruritus is generalized, the rhythm may be broken and the scratch-itch, itch-scratch cycles occur so closely together as to be practically continuous.

TREATMENT

THE ideal treatment for itching is the removal of the cause. This may be accomplished readily in scabies and pediculosis, and in some cases of urticaria, infantile eczema, pruritus ani or vulvae, drug eruptions, plant dermatitis, industrial dermatitis, atopic eczema, and fungus infections.

However, there is a host of skin diseases and manifestations, of known or unknown etiology, in which the demand for the relief or control of itching is imperative and takes precedence over all other considerations.

Hormones: ACTH and cortisone derivatives are the most effective agents for the control of pruritus, either by direct action or by temporarily suppressing the dermatoses which give rise to the itching. These drugs should be used for short periods only, and be withdrawn by graduated reduction. As soon as the itch is alleviated other modalities should be substituted.

Estrogenic hormones are seldom indicated in the treatment of itch; in some cases of pruritus vulvae, occurring at the climacteric, they may be useful.

Sulfapyridine is usually effective for the relief of itching in dermatitis herpetiformis.

Calcium gluconate or calcium bromido-lactogluconate, intravenously, may help, as may aspirin or codeine orally.

Tranquilizers, antihistamines, sedatives and hypnotics aid by depressing the sensorium. The ideal drug with selective action at the thalamic level has not yet been found.

Wet dressings: Soaks and wet dressings help to reduce inflammation and itching and are especially valuable in acutely inflammatory, exudative dermatoses. For example: potassium permanganate, 1 to 8000 solution; or 2 per cent boric acid; or 1-to-20 aluminum acetate solution.

The dressings are prepared by soaking gauze or linen in the solution and applied "soppy" but not "running." The solution should be poured over the dressing at intervals to keep it wet. It is generally not covered with oil cloth or cellophane as in a surgical wet dressing.

Baths: Two teaspoonsful of potassium permanganate crystals to 50 gallons of water. Oatmeal or linit starch (colloid baths) to which coal tar solution may be added. Colloid baths are the mildest types of water cleansing and are valuable in most cases of generalized pruritus.

Lotions: Aqueous or alcoholic solutions in which powders and other medicaments are suspended with the aid of glycerine, and which dry on the skin after the water or alcohol is evaporated. Lotions are soothing and antipruritic and are especially suitable for working and ambulatory patients.

Example:

Zinc oxide	18. to 24.
Talc	18. to 24.
Glycerine	12.
Diluted alcohol (USP) or distilled water qs	120:0

To this lotion base may be added menthol, camphor, phenol, resorcin, coal tar solution, and bentonite (1 to 2 per cent for flesh tint).

Emulsions: Usually of two types.

(a) Water in oil which provides a continuous oil phase in contact with the skin thus affording a protective oil film. Example:

Carron oil	60.0
Olive oil	60.0
Lime water qs	120.0

Another example:

Neocalamine liniment (USP) as follows:

Prepared Neocalamine	15.0
Olive oil	50.0
Calcium hydroxide solution qs	100.0

To which menthol, phenol, and coal tar solution may be added.

(b) Oil in water. This provides a continuous aqueous phase in contact with the skin. Evaporation of the aqueous phase results in a cooling sensation. Burow's emulsion is an example:

Zinc oxide	30.0
Talc	30.0
Anhydrous lanolin	30.0
Aluminum acetate solution	6.0
Sorbitan monostearate	6.0
Olive oil	120.0
Distilled water qs	300.0

To this may be added menthol, phenol, camphor, resorcin, or coal tar solution.

Emulsions are most often used in acute and subacute inflammatory dermatoses accompanied by edema, exudation and vesiculation.

Ointments: Consist of animal and vegetable fats and derivatives of petrolatum. For example:

Zinc ointment (USP)

Zinc oxide	20.
White wax	6.
Liquid petrolatum	15.
White petrolatum qs	100.

Ointments may be of water in oil type which provide an internal aqueous phase and a continuous oil phase in contact with the skin, affording a protective oil film.

Example: Hydrophilic petrolatum (USP)

The oil-in-water type provides an internal oil phase and an external aqueous phase in contact with the skin.

Example: Hydrophilic ointment (USP)

Ointments are indicated in chronic, dry, thickened, scaling and lichenified dermatoses. They help to remove scales and crusts, soften and lubricate the surface of the skin, and carry medicaments insoluble in other vehicles. Antipruritic agents such as menthol, camphor, phenol, liquid coal tar, and ichthammol may be added.

Pastes: Ointments to which large amounts of powders have been added. Thus, Lassar's Paste (USP) consists of:

Zinc oxide	25.0
starch	25.0
petrolatum	50.0

To which crude coal tar may be added for its antipruritic effect.

Pastes are valuable in the management of localized exudative, vesicular and crusted eruptions. They are absorbent, soothing and protective, and should be bandaged for maximum effectiveness. The activity of drugs incorporated in pastes is considerably reduced as compared with ointments.

Pastes may be removed from the skin with light mineral oil. The latter is an excellent lubricant and detergent for use in soap sensitive skins, infantile eczema, hand eczemas, atopic dermatitis and eczematized skins.

In general, wet packs and emulsions should be used in acute inflammatory dermatoses and ointments in chronic, dry dermatoses.

Any medicament applied to an inflamed surface may cause a reaction. It may result from a specific hypersensitivity to one or more of the ingredients, or the medicament may act as a primary irritant in the specific inflamed area. An ointment applied to the normal skin of an individual may not precipitate any untoward reaction; yet the same ointment applied to an inflamed skin area, in the same individual, may elicit a severe reaction.

SUMMARY

1. There is a peripheral and a thalamic threshold for itch. The latter is the more important.

2. In the vast majority of skin and constitutional diseases characterized by itching, the itch serves no useful purpose.

3. The resultant scratching damages rather than helps the condition present.

4. The itch sensation and the pleasure evoked by scratching are exalted and intensified in the cerebral sensory cortex of man.

5. This phenomenon often leads to overindulgence in, and at times outright perversion of, the scratch reflex.

6. The treatment of itching should be directed toward the removal of the cause. When this is impossible (or even sometimes when it is possible) an attempt must be made to control the existing itch which is usually the chief symptom, no matter what the etiology, so far as the patient is concerned.

7. ACTH and cortisone derivatives are by far the most effective drugs in the alleviation and control of itch, but their use is circumscribed.

8. Tranquilizers, antihistamines, sedatives and hypnotics aid to varying extent, chiefly by dulling the sensorium.

9. As a general rule, wet packs and colloid baths are used in the acute inflammatory, exudative conditions; creams and ointments in the chronic, dry types of dermatitis.

10. Psychotherapy in the form of explanation of the mechanism and by repeated suggestion is important in all forms of pruritus; and at times, the most important form of therapy.

No attempt is made to list all the soap substitutes, creams, oils, cortisone derivatives, emulsions, ointments and so on. Many fine pharmaceutical houses make equally efficacious preparations and it would be unfair to omit any.

For swift reference, I suggest the compact *Dermatologic Formulary*. It is edited by Dr. Frances Pascher and is published by Hoeber-Harper in New York.

415 Prospect Street

Roy Pollack, M.D.

Englewood

Aminophylline Poisoning in Childhood

Rectal administration of aminophylline is a po tentially dangerous procedure, and, as this pape shows, may cause fatal complications. The ora route is safer as Dr. Pollack here points out.

Aminophylline has been used extensively in the treatment of asthmatic conditions over twenty years. The drug exerts a powerful bronchodilating effect. Unfortunately, it is also capable of producing the most severe toxic reactions in patients of all ages, especially in early childhood. Reports on fatalities from aminophylline have appeared in the literature since 1943 when Merrill[1] described the three deaths resulting from the intravenous use of aminophylline in adults. Since then, many reports[2] concerning aminophylline poisoning have appeared in the literature. A description of the dangers inherent in the use of aminophylline in children may alert physicians to the potential toxicity of a drug often prescribed too casually.

A nine-month old baby girl with no history of previous illness became ill about 36 hours prior to admission to the Englewood Hospital with a temperature of 104, cough, wheeze and tachypnea. A physician summoned at this time made diagnosis of asthmatic bronchitis, administered 300,000 units of penicillin intramuscularly and prescribed oral tetracycline 125 milligrams, four times a day.

The next day her temperature was down to 101 but the respiratory difficulties were still present. The physician prescribed a proprietary suppository containing theophylline 130 milligrams, ephedrine hydrochloride 25 milligrams and phenobarbital 12 milligrams. This suppository was repeated five hours later. A few hours after the second suppository the baby became extremely restless and developed a temperature of 106.

On admission to the hospital, the child was agitated, very dyspneic and cyanotic. A loud expiratory wheeze, dry rales and rhonchi were heard throughout the chest. A pediatrician diagnosed this as theophylline poisoning. Soon after admission the infant had a convulsion. Convulsive movements continued off and on until she died. Terminal events were hyperpyrexia of 108, depressed respiration and hematemesis of "coffee ground" material. Hospital treatment consisted of sponging, oxygen, intramuscular phenobarbital, epinephrine, cortisone and antibiotics. No laboratory data were obtained since the child died about five hours after admission.

Postmortem examination revealed bluish-grey triangular and wedge-shaped areas on the lung surface. The remainder of the lung was slightly emphysematous and light pinkish-grey in color. The bronchi and distal bronchioles were partly filled with yellow mucoid material. The lung beneath the dark cyanotic surface areas showed dark red parenchyma against light reddish-pink lung tissue. There was slight exudation of pinkish frothy material from both lungs. Gross pathologic diagnoses were: bronchitis, capillary bronchiolitis, partial atelectasis of lungs plus compensatory emphysema.

Microsections of the lungs showed the bronchi and bronchioles to be filled with polymorphonuclear leukocytes. The bronchiolar epithelium was partly desquamated and infiltrated with polymorphonuclear leukocytes. Surrounding the bronchioles was some round cell infiltration. Many of the smaller bronchioles were broken down. At these junctions the alveoli contained masses of polymorphonuclear leukocytes in some cases mixed with red blood cells. Other sections of the lungs showed the alveoli to be partially filled with a pinkish staining amorphous fluid. There was no pneumonitis. Culture of the trachea yielded Pseudomonas aeruginosa and Streptococcus fecalis.

1. Merrill, G. A.: Journal of the American Medical Association. 123:1115 (1943).

2. Soifer, H.: Journal of Pediatrics, 50:657 (1957). Also see papers by Veum, J. *et al.* (Journal of Pediatrics, 49:703, 1956); by White, B. H. and Daeschner, C. W., (Journal of Pediatrics, 49:262, 1956); by Rounds, V. J., (Pediatrics, 14:528, 1954); and by Nolke, A. C., (Journal of the American Medical Association. 161:693, 1956).

The findings in this case are remarkably similar to the histories of aminophylline poisoning in childhood which have appeared in the literature. The suppositories administered to this child contained theophylline rather than aminophylline. However, since aminophylline is merely theophylline combined with ethylenediamine to enhance its solubility and since theophylline is usually employed as aminophylline, I took the liberty of using the more familiar word in the title of this paper.

Theophylline is a xanthine derivative. Caffeine and theobromine are the other well known xanthines. According to Goodman and Gilman,[3] these drugs exert similar pharmacologic effects: stimulation of the central nervous system including the respiratory center, certain smooth muscle relaxation, diuresis, coronary artery dilatation, stimulation of the myocardium and skeletal muscle stimulation. However, there is considerable variation among these drugs in their relative ability to achieve these therapeutic results. Thus caffeine is used for central nervous system and respiratory center stimulation since it exerts this effect more strongly than the other xanthines, and theophylline is used for relaxation of the smooth muscle of the bronchi since it excels in this particular function.

Aminophylline toxicity produces a striking clinical picture. The similarity of the symptomatology of all the reported cases of toxic reaction to this drug is remarkable. The early and somewhat more benign symptoms of impending trouble are restlessness and vomiting. The serious implication of restlessness is often overlooked, being erroneously attributed to the asthmatic condition rather than the drug used in the treatment of this condition. The restlessness and irritability become rapidly more intense, soon resembling maniacal agitation. The patient will scream, throw himself about in a manner never witnessed in asthma uncomplicated by aminophylline therapy. Likewise the vomiting may surpass in severity anything observed in uncomplicated asthma. The vomiting is refractory to treatment and dehydration may develop with alarming rapidity. An unfavorable and frequent development is the appearance of bloody or "coffee ground" vomitus. Ulceration of the stomach and esophagus has often been observed at necropsy. Unquestionably much less difficulty is encountered with the oral than the rectal administration of aminophylline because vomiting acts as a safety valve in the former route and eliminates the toxic drug.

THE most ominous symptoms of aminophylline toxicity are convulsions and hyperpyrexia. Twitchings or generalized convulsions may occur and are refractory to anticonvulsant treatment. The agitation and convulsions probably bear some relationship to the especially high degree of central nervous stimulation which xanthine derivatives produce in children. The hyperpyrexia of aminophylline poisoning like the other symptoms already mentioned is extreme; readings of 108 are common. The high fever is resistant to the usual antipyretic measures. All the symptoms of aminophylline poisoning have one characteristic in common: they are extreme and difficult to treat. Coma and vasomotor collapse are often terminal events.

In 1957, Soifer[2] reviewed and analyzed all the reported cases of aminophylline poisoning. Up to that time 33 cases had been reported with ten deaths. It seems reasonable to assume that many cases of poisoning due to this drug have not been reported. In the community where I practice, I recently learned of two fatal reactions to aminophylline in addition to the one summarized in this article.

Soifer's excellent review[2] reveals much interesting data. The mean age of the reported cases was 27 months with 82 per cent of them in children three years and under. It is especially hazardous to use this drug in young children. Also important is the relationship of the incidence of aminophylline poisoning to the method of administration. In 24 of the 33 cases reported the drug was administered rectally. The conclusion is inescapable: rectal aminophylline suppositories are potentially dangerous.

3. Goodman, L. and Gilman, A.: The Pharmacologic Basis of Therapeutics. New York 1955. Macmillan, Ed. 2. Page 339 *et. seq.*

What causes these reactions? Is it overdosage or hypersensitivity? Both factors are involved. Since we cannot control drug idiosyncrasy we must direct our attention to dosage. Aminophylline is usually administered to children orally or rectally. A useful orientation point would be the calculation of the pediatric dosage on the basis of the adult dosage. Oral preparations for adults contain 100 to 200 milligrams and rectal suppositories 500 milligrams. On a strict body weight comparative basis children should receive 1.5 to 3 milligrams per kilogram orally and 7 milligrams per kilogram rectally (calculations based on average adult weight of 70 kilograms). Students of aminophylline toxicity favor these small doses; Soifer [2] feels that an even smaller rectal dose (5 milligrams per kilogram) would be safer and still effective. In Soifer's review of the fatal cases the average rectal dose was 22 milligrams per kilogram of body weight. The patient reported in this article received 14 milligrams per kilogram. A proprietary suppository now available for pediatric use contains as much as 250 milligrams of aminophylline—a dose appropriate for a 36 kilogram child (calculated on the basis of 7 milligrams per kilogram). Yet these suppositories are frequently prescribed for infants on the fallacious assumption that these are safe since they are labelled "half strength" or "for infants and children."

In considering dosage it is also important to pay heed to the question of the frequency of administration of aminophylline. Rectal absorption of aminophylline is capricious. Sometimes low levels are found as early as five hours after a suppository is inserted. In other cases, high levels are present nine hours later. To avoid cumulative effects, the drug should be given no more often than every 12 hours.

SUMMARY

1. Aminophylline is a drug to which sensitivity is not uncommon. The dosage allows only a small margin of safety. Oral administration is reasonably safe since vomiting is an early development in toxic reaction and eliminates the drug.

2. The inconvenience of intravenous administration in small children fortunately renders this route unpopular. The pain and tissue reaction associated with intramuscular aminophylline precludes this mode of administration.

3. The ease of ordering rectal suppositories makes this route tempting. Here lies the grave danger of aminophylline poisoning. A child does not die of asthma but may die from the treatment of asthma. It is questionable whether the rectal administration of aminophylline is ever indicated. Oral aminophylline may be used with reasonable safety provided one is familiar with the proper dosage and fully cognizant of its toxic potentialities.

275 Engle Street

More Hospital Beds?

Are our facilities for medical care adequate? More hospital beds are required to meet our health needs, according to the May 1959 issue of *Patterns of Disease,* prepared by Parke, Davis & Company.

Hospital beds per 1000 persons in the United States now average 7.8; but this should be increased to 13—an increase of almost 70 per cent—to meet the ratio prescribed in the Public Health Service Act. In nursing homes, 3 times as many beds as those currently available are requireed to meet the prescribed ratio.

Of beds needed, *Patterns* reports, about 42 per cent are earmarked for mental hospitals, 37 per cent for general hospitals, 16 per cent for chronic disease hospitals, and the remainder for tuberculosis hospitals.

Archie Crandell, M.D.

John Y. Ma, M.D.

Greystone Park

Jaundice Precipitated by Prochlorperazine (Compazine®)

In the Treatment of Alcoholic Psychiatric Disturbance

Effective drugs often produce side effects too. The more potent the drug, the more alert we must be to this possibility. As an example here is a case of jaundice precipitated by prochlorperazine. Fortunately it was picked up and corrected in time.

Prochlorperazine has been successfully used in a wide range of application in daily practice.[1] Its toxicity has been low, therefore side effects are infrequent and mild.[2] In some instances extra-pyramidal symptoms are encountered.[3] At times the patient shows signs of restlessness, of being jittery and sleepless, but these symptoms disappear with reduction of dosage or by concomitant administration of mild sedatives. It has been asserted that there is little effect on the blood pressure and that the drug does not lower the threshold of convulsions. Blood dyscrasias may result, and meningeal irritation has been noticed in children.[4] So far there has been no report of jaundice attributable to this drug. We have had an opportunity to observe jaundice in a patient being treated with prochlorperazine.

A 26-year old, married man was first admitted to this hospital on September 4, 1957, because of alcoholism. He had been drinking since 1952 and occasionally became intoxicated. Past history contained no evidence of jaundice. On admission he showed generalized tremor and visual hallucinations. He was confused and totally disoriented. Laboratory findings were essentially negative. He was placed on chlorpromazine, 50 milligrams three times a day. After two days this was increased to 100 milligrams three times a day. Mental symptoms gradually cleared and he was allowed to go home on September 26, 1957 with the provision that he continue his treatment. On March 4, 1958, he was returned to the hospital for alcoholism. During his second admission he was continued on the same dosage of chlorpromazine, 100 milligrams three times a day and showed no side effects. His mental symptoms cleared and he was allowed to go home again on March 20, 1958. He returned to the hospital for the third time on August 18, 1958, because of a similar episode. While he was out, prior to his third admission, he took chlorpromazine infrequently. During his third admission he was found to have moderately advanced, active pulmonary tuberculosis. Sputum examinations were positive for tubercle bacilli, both in smear and culture. Physical examination was essentially negative except for signs of active pulmonary tuberculosis in both apices. He was restless, confused and tremulous and was placed on prochlorperazine, 10

1. Freyhan, F. A.: Prochlorperazine in Psychiatric Disorders; Presented at Eastern Regional Research Conference, Am. Psychiat. Assoc., Phila. (Nov. 16) 1956. Also, Goldman, D.: Effect of Prochlorperazine (Compazine) on Psychotic States, *ibid.*

2. Vischer, T. J.: Clinical Study of Prochlorperazine. New Engl. J. Med., 256:26 (Jan. 3) 1957. Also Wennersten, J. R.: Office Treatment of Pain and Psychic Stress. Clin. Med., 3:1179 (Dec. 6) 1956.

3. Freyhan, F. A.: Psychomotility and Neuroleptic Therapies (Chlorpromazine, Reserpine, Prochlorperazine), *Nervenarzt*, 28:504 (Nov. 20) 1957.

4. Jabbour, J. T.: Neurologic Manifestations in Children Receiving Compazine (Prochlorperazine), J. Pediat., 53:153 (August) 1958.

milligrams three times a day by mouth, on August 20, 1958. His mental symptoms gradually subsided. On September 14, 1958, he abruptly developed chills and fever, with bulbar jaundice. Within three days the jaundice became generalized. Urinalysis revealed bile and urobilinogen; icteric index was 100; immediate direct van den Bergh reaction; total serum bilirubin, 2 per cent. Cephalin flocculation test was 1 plus after 24 hours and 2 plus after 48 hours. Treatment with prochlorperazine was immediately discontinued. He was placed on high vitamin, high caloric, low fat diet. At this point, he again became "nervous" and depressed. He attempted suicide by cutting into veins of both wrists because of auditory hallucinations. He was then placed on heavy sedation and gradually recovered from his confusion. Repetition of the laboratory tests during the period of jaundice yielded essentially the same results as previously. On October 6, 1958, the jaundice began to subside. Because of his mental symptoms he was given a different tranquilizing drug. Laboratory tests taken on November 18 revealed a normal blood count; urinalysis, negative for bile; icteric index 14; serum cholesterol, 182 milligrams per cent; van den Bergh reaction immediate direct; total serum bilirubin, 0.4 milligrams per cent; bleeding time, 1 minute 25 seconds; coagulation time, 4 minutes 20 seconds; erythrocyte fragility test negative; cephalin flocculation test and BSP were both negative. Up to December 15, 1958 there has been no return of jaundice. The patient appeared to be relaxed, cheerful and was no longer nervous or confused. By that date he had gained 16 pounds from his date of last admission.

Chronic alcoholism has been considered as a manifestation of a psychoneurosis. The alcoholic is difficult to help because he is unreliable and unable to adjust to his emotional stress. Prochlorperazine has been considered to exert a beneficial effect in such conditions by lessening the pathogenesis of the tension and thus reducing the urge to drink.[5] Since side effects have been considered minimal it is thought to have a wide margin of safety in daily clinical practice. Jaundice has not been reported previously in the course of treatment with this drug. In this case the patient was treated previously with chlorpromazine. No jaundice was noted. Furthermore, this patient had been drinking heavily for the past six years and was intoxicated frequently. It is interesting to note that when jaundice began his liver function test was considered as within normal limits, even though other laboratory findings were positive for jaundice and that the liver function test became positive about three weeks later, when the clinical jaundice gradually subsided. Subsequent laboratory findings were negative, from which we conclude that no permanent hepatic damage had occurred. The patient was given another tranquilizing drug and has been taking this for over a period of one month and at the time of this writing, there was no evidence of jaundice having developed. It would seem, therefore, that prochlorperazine precipitated this patient's jaundice.

5. Kline, N. S., Barsa, J. A., Bruckman, N. S. and Saunders, J. C.: Compazine (Prochlorperazine) in a Variety of Psychiatric Conditions, Journal of Pediatrics, 53:510 (August) 1958.

SUMMARY

A CASE of jaundice precipitated by prochlorperazine is reported. The patient was treated first with chlorpromazine for ten months without evidence of jaundice. When the patient received prochlorperazine, clinical as well as laboratory jaundice appeared. The symptoms subsided after withdrawal of this drug. Subsequent laboratory reports failed to demonstrate residual damage. Recovery was uneventful. The patient has since been treated with another tranquilizing drug and no jaundice has developed thus far.

The State Hospital

Rita Finkler, M.D.

Newark

Liothyronine as a Replacement for Thyroid Therapy

Desiccated thyroid and thyroxine sometimes prove ineffective. The synthetic thyroidal hormone, liothyronine, on the other hand, is found to be potent and well tolerated under the conditions specified in Dr. Finkler's study.

Studies by Gross and Pitt-Rivers[1] indicate that liothyronine is the thyroid factor ultimately responsible for cellular metabolic activity. Subsequent studies[2,3] by others show that the drug is often effective when desiccated thyroid and L-thyroxine proved ineffective. To evaluate its clinical usefulness relative to that of thyroid preparations, liothyronine was administered to 166 patients showing characteristic signs and symptoms of hypothyroidism. The report summarizes the results of an evaluation conducted during the past three years.

Patients were selected on the basis of their having a subnormal metabolic rate (BMR) in addition to one or more of the following: dry skin, dry hair, obesity with easy weight gain, menstrual irregularities, easy fatigability, and general lassitude. All were seen in private practice. Of the group, 71 had been receiving desiccated thyroid or thyroglobulin; all discontinued these preparations for a week or longer before they began liothyronine therapy. The remaining 95 patients had not previously been given thyroid preparations. BMR and serum cholesterol levels were determined for all patients before, during, and after therapy. Initial protein bound iodine (PBI) tests were carried out in 30 per cent of the patients. Patients in whom normal values were found were not rechecked; others failed to return for further study. Two patients had initial radioactive iodine uptake studies which were not repeated since they yielded normal results.

Eleven representative patients who were cooperative (followed dosage instructions, kept appointments) and who had some power of self observation, were selected for special study. Determinations of BMR, protein bound iodine (PBI), and serum cholesterol levels were made on them before, and periodically during, liothyronine therapy. Four of these patients had previously received desiccated thyroid.

DOSE

Liothyronine dosage was established on an individual basis and adjusted in accordance to patient response. Initially, patients were given 25 micrograms (one tablet) daily for one week. Those who benefited without experiencing side effects were maintained on this dosage. In those who tolerated the drug without showing clinical improvement, the dosage was raised gradually until response was obtained or side effects supervened. Most pa-

1. Gross, J. and Pitt-Rivers, R.: Lancet, 1:593 (1952).
2. Frawley, T. F., *et al.*: Journal of the American Medical Ass'n., 160:646 (Feb. 25) 1956.
3. Gold, A.: Canadian Services Medical Journal, 12:619 (July) 1956.

tients could be maintained on 50 to 75 micrograms daily without discomfort.

RESULTS

THE charts summarize the effect of liothyronine therapy on BMR, on PBI and on serum cholesterol levels, respectively, in the eleven patients selected for special study. In general, low BMRs were elevated; PBIs remained essentially unchanged; and high cholesterol levels were lowered. Changes in the latter were often marked, especially in patients whose pretreatment levels were 300 milligrams per cent or over. In these patients, decreases ranged from 32 to 200 milligrams per cent. Provocative as these findings may be, it should be noted that liothyronine (since it is physiologically related to thyroxine) should be used with extreme care in patients with cardiovascular disorders.

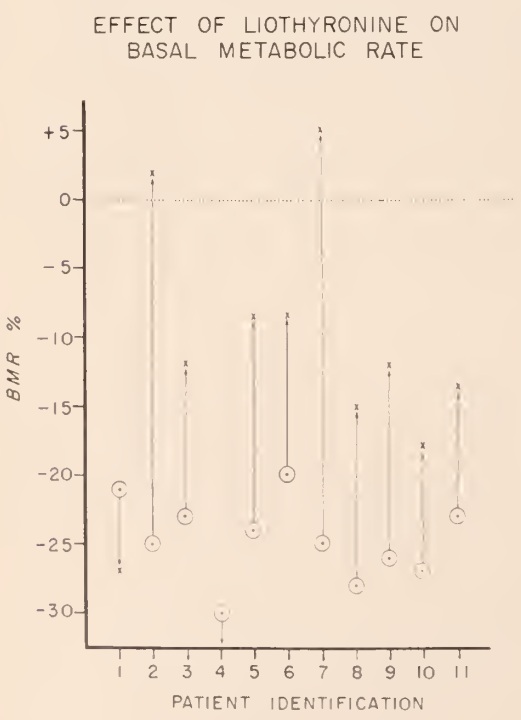


Figure 1. Pre-treatment BMR is indicated by ⊙. Post-treatment BMR in the same patient is indicated by x. Average length of treatment—2 months. As can be seen from the chart, only two patients (No. 1 and No. 4) showed a lowering of BMR; the other nine patients showed an increase in BMR.

These findings, for the most part, parallel those of other investigators;[2-4] they differ slightly from findings by Selenkow and Asper[5] who report that liothyronine decreases PBI levels.

Patients who had been treated previously with thyroid preparations were, when placed on liothyronine, adequately maintained. There were no unfavorable reactions, nor any decrease in clinical response. (Our findings indicate that 25 micrograms of liothyronine proved equivalent to about one grain of desiccated thyroid.) Fifteen patients who had had incomplete symptomatic relief on thyroid preparations obtained beneficial results with liothyronine. Typical of the response seen in these patients was that of a 17-year old girl whose complaints included amenorrhea, obesity, dry hair and skin, chronic fatigue, constipation, and sensitivity to cold. Previous therapy had been desiccated thyroid (½ grain daily), estrogens

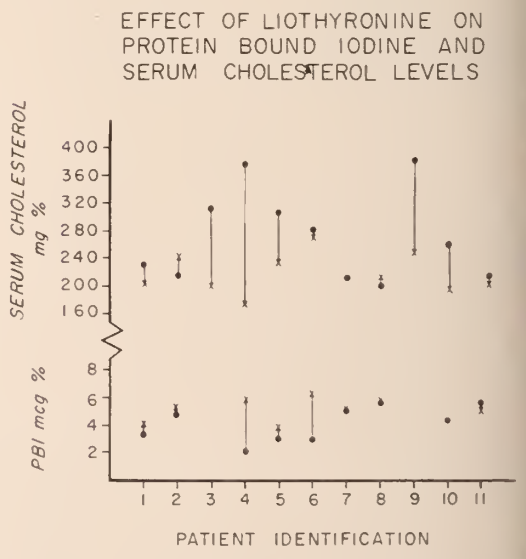


Figure 2. Pre-treatment levels are indicated by •. Post-treatment levels in the same patient are indicated by x. Average length of treatment—2 months. As can be seen from the chart, six patients showed a decrease in serum cholesterol, one showed an increase, and the others remained essentially unchanged. Protein bound iodine levels were increased in two patients and remained essentially unchanged in the rest of the group.

4. Lerman, J.: Journal of Clinical Endocrinol & Metab., 13:1341 (Nov.) 1953.

5. Selenkow, H. A. and Asper, S. P., Jr.: Journal of Clinical Endocrinol. & Metab., 15:278 (Mar.) 1955.

Premarin® 0.625 milligrams twice a day) and itamin A (25,000 units, twice a day) with ncomplete symptomatic relief. Laboratory ests, one week after desiccated thyroid was iscontinued, showed PBI and serum choles- erol levels to be within normal limits (4.9 icrograms per cent and 218 milligrams per ent, respectively) while the BMR was minus 6. On liothyronine, she became less lethargic, nd more energetic, within 2 weeks. There as a loss of weight and an increase in men- al alertness. Gradually, her menstrual cycle ecame more regular, in contrast to her pre- reatment amenorrhea. After three months' herapy, symptomatic improvement was com- lete. Laboratory studies at that time showed hat the BMR was raised to plus 2 while PBI and serum cholesterol levels remained ithin normal limits.

Generally speaking, obese patients in the roup who had reached a plateau in losing eight on thyroid therapy began to lose weight gain when placed on liothyronine. An inter- sting example is a 44-year old housewife, hose weight gain had been checked and whose omatic complaints diminished slightly on des- cated thyroid (1 grain twice daily). She re- ained unsatisfied with therapy because of ailure to lose more weight. Unable to toler- te desiccated thyroid in higher dosage, she as started on liothyronine (25 micrograms wice daily) after a week's respite from desic- ated thyroid. Laboratory studies just before othyronine was started showed: BMR minus 6; PBI 4.9 micrograms per cent; and serum holesterol was 218 milligrams per cent. With- n a week the patient reported that she felt etter, and was not "tired all the time." On ontinuing the medication for 3 months she ost 12 of her 170 pounds; her hair became soft nd glossy in contrast to its pretreatment oarse, brittle texture. And, in spite of clinical mprovement, laboratory studies repeated dur- ng liothyronine therapy showed marginal changes: BMR dropped to minus 27; PBI to 3.3 micrograms per cent, and serum choles- terol to 201 milligrams per cent.

Previously untreated patients with hypo- thyroidism obtained rapid symptomatic relief when given liothyronine. Within a week or so they usually reported feeling better, of being "less tired" and "more active," of having in- terest in tasks that had seemed difficult and monotonous (shopping, attending social and church functions, entertaining house guests). In contrast to psychic changes, such as lessen- ing of psychogenic fatigue and apathy, im- provement in physical status occurred gradu- ally, usually over a month's time or more, al- though weight loss often became evident with- in two weeks after therapy was started. In general, results in this group, compared with thyroid therapy in the other group, indicated that the onset of liothyronine's action occurred more quickly; once established, its action sub- sided quickly upon withdrawal of the drug.

SUMMARY

LIOTHYRONINE, a synthetic thyroidal hor- mone, was evaluated over a three-year pe- riod in 166 patients with hypothyroidism. La- boratory studies showed that it elevated a low metabolic rate, but had little effect on protein- bound iodine and generally lowered serum cholesterol level, especially in those whose pre- treatment levels were over 300 milligrams per cent. (See the charts). Liothyronine (25 micro- grams) proved a suitable replacement for des- iccated thyroid (1 grain) and often provided beneficial results in patients whose response to desiccated thyroid had been incomplete. Moreover, its onset and termination of action is more rapid than that of desiccated thyroid; consequently, it is fairly easy to manipulate dosage. It seems especially useful in patients intolerant to desiccated thyroid.

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Clinical Aspects of Diarrhea*

You wouldn't associate the treatment of diarrhea with a philosophy. But Dr. Fradkin here offers not only a technic, but also a concept of patient management.

If I were suffering with diarrhea, I would want my physician to be a kindly gentleman, extremely patient, thorough and understanding. He would thus lessen my embarrassment because no complaint is more embarrassing to the patient than diarrhea. He would lessen my anxiety because with all the publicity about cancer, I as the patient, would be greatly worried. By his thoroughness and understanding he would instill more confidence in his treatment and would make my recovery more hopeful.

In return my physician would receive, freely and unhesitatingly, statements and clues pertaining to my present and past state of health. He would receive information regarding the health, past and present, of my parents, brothers, sisters, wife and children. I would reveal to him my past treatments, my sensitivities, my likes and dislikes, my daily routine, good or bad. In other words, I would feel like his associate in search of the specific cause and very best treatment of the diarrhea. Thoughtful inspection including the use of the sigmoidoscope, palpation including rectal digital exploration, percussion and auscultation would guide his physical examination.

If I were an ambulatory patient, my physician would give me a detailed diet composed of three basic meals and three in-between meals. The diet would be high in calories, high in proteins, rich in vitamins and minerals, and low in residue. The foods would be easily absorbable, non-stimulating to peristalsis, readily obtainable and easily prepared. Complicated recipes would be avoided. He would consider canned fruits and vegetables just as nutritious and wholesome as the fresh variety. Their choice eliminates chores which are time consuming and exhausting. The time saved can be used to greater advantage for essential rest periods. He would explain that fruit juices such as orange, grapefruit and tomato in 4 to 6 ounce servings at the beginning of each meal, or with the meal, do *not* precipitate bowel evacuations especially when the juices are at room temperature and sipped slowly. He would advise that all meats be well done. Rare or incompletely cooked foods are difficult to digest. Raw foods are bulky and over-distend the stomach. They mechanically irritate the intestinal lining and thus increase peristalsis. My physician would not allow foods prepared with horse-radish, mustard, pepper or other stimulating spices. All foods could be salted to taste. He would encourage the use of lemon juice on fish or in tomato juice. He would advise against the use of rich cakes, candy, chocolate and gum, tobacco, alcoholic beverages, soups and fresh milk.

If I was inquisitive about these restrictions, he would explain that tobacco stimulates peristalsis, and frequently diminishes the appetite. Cake, candy, chocolate and gum lead to dis-

*Presented by invitation at the 193rd Annual Meeting of The Medical Society of New Jersey, Section on Gastroenterology and Proctology, April 29, 1959.

tention and a feeling of fullness. Alcoholic beverages often increase peristalsis and interfere with dietary discipline. Soups satisfy the appetite, limit the intake of solid foods, but have very little caloric value. They are also gas producing. He would prefer evaporated milk because of its hypo-allergenic properties, its sterility and low curd tension which favor digestion. He would also explain why strict adherence to this diet is essential for effective control of the diarrhea.

During the subsequent three or four visits my physician would repeatedly examine the stools and rectal aspirations for inflammatory cells and intestinal pathogens. He would do a urinalysis, complete blood count, blood chemistry, and finally, a gastrointestinal x-ray series always including an air-contrast barium enema. An hourly small bowel study would be done if indicated. My physician would obviously not send to the laboratory for bacteriologic examination a stool specimen containing barium, bismuth, sulfonamide drugs, antibiotics or suppositories. Laboratories are constantly requested to examine and culture stools containing one or more of these antiseptic ingredients.

My physician would re-emphasize the importance of the diet, regularity of meals, supplementary vitamins and physical and mental rest at each visit. He would periodically check my weight to evaluate the adequacy of my food intake. He might also speak to members of my family to obtain their cooperation in the solution of problems within their sphere. At no time would my doctor give me the impression that he was disinterested, bored or unreasonably curt.

When the reports of all these special examinations have been received he would correlate the findings with the history and physical examination before a specific or probable etiologic diagnosis was made. He would then outline for me the treatment in considerable detail and in clear and simple language. If further consultation was necessary, he would so advise me.

If I were suffering with severe diarrhea and the rectal discharges numbered from 10 to 20 in 24 hours, he would probably recommend immediate hospitalization. At the hospital there would be a close association between the physician and the patient's attendants including the interns, nurses, aides and dietitian. Every sign or symptom noted by any member of these departments would be a reflection of the patient's physical and mental state. A good sign would be comforting, of course. A bad sign would lead to a re-evaluation of the treatment or management. Consultation with a colleague would always be considered. The hospital plan would consist of the following:

1. Complete bed rest
2. Diet as described above
3. Psychosomatic approach
4. Complete laboratory investigation
5. Parenteral replacement therapy
6. Control of infection
7. Anti-inflammatory agents
8. Antispasmodic and sedative drugs

Complete bed rest would mean complete physical and mental relaxation. Bathroom privileges would not be granted until the frequency of the bowel movements were cut in half and the temperature remained normal for at least 48 hours. Visitors, radio and television would be limited.

Psychosomatic therapy would include sympathetic, reassuring, friendly, sincere and unhurried discussion of all physical and emotional complaints. He would stress the fact that "nervous tension" itself may cause overactivity of the intestinal tract.

Laboratory investigation would include urine, stool, blood and x-ray studies as outlined previously for the ambulatory patient. Analysis of gastric, duodenal and pancreatic secretions would be done only if indicated. Unnecessary "work-ups" would be avoided.

Parenteral replacement therapy would be started immediately upon admission to the hospital. One, two or more liters of electrolyte solution containing sodium, potassium, calcium, lactate and magnesium with 10 per cent carbohydrate would be given intravenously. To this solution would be added an antihistaminic and massive doses of all the soluble B complex vitamins plus folic acid and vitamin K. The amount and type of solution would depend upon the clinical condition of

the patient and the blood chemistry. The anemia would be corrected by the administration of whole blood or packed red cells. The hypoproteinemia would be corrected by the use of plasma or serum albumin. Casein hydrolysate would be used cautiously because of its tendency to increase diarrhea. Intravenous fluids and vitamins with or without blood would be given daily until the blood chemical picture was corrected and the patient was able to take and retain food and fluids by mouth. If the anemia were severe iron would be administered intramuscularly.

Specific and secondary infections of the intestinal tract would be controlled by one or more of the sulfonamides, antibiotics or antiprotozoan drugs. An autogenous vaccine would be used if a bacterial pathogen was isolated. My physician might choose one or more of the following† antibacterial and antiprotozoan agents: Azulfidine®, Thalamyd®, sulfaguanidine, Sulfathaladine®, penicillin and streptomycin, Chloromycetin®, erythromycin, Achromycin®, Diodoquin®, Milibis-Aralen®, Enterovioform®, carbarsone, emetine hydrochloride, and Terramycin®.

Anti-inflammatory agents such as ACTH and prednisone would be used only for arthritic, allergic, difficult or desperately ill patients. Close observation would be maintained to determine whether dosage should be increased, decreased or entirely discontinued. Sulfonamides or antibiotics would be continued during active hormone therapy to counteract the tendency of the corticosteroids to mask infection. Sedatives, antispasmodic drugs such as the barbiturates, anticholinergics and tranquilizers would be used only when indicated to reduce the unusual sensitivity of the patient as well as the overactivity of the colon.

My physician would consider diarrhea as a beneficial and protective mechanism of the body; an emergency measure which serves to clear the intestinal tract of excessive chemicals, gases, toxins or other irritants. Therefore, opiate mixtures would be considered unphysiologic. They would interfere with intestinal drainage. Such medication would give my physician a false sense of security about my condition. Opiates and opiate mixtures are often responsible for the fever and the difficulty these patients have in completely evacuating their bowels. My doctor would not use antimicrobial remedies before attempting an etiologic diagnosis for fear that they inhibit rather than destroy the invading pathogen.

My physician would use moist heat to relieve pain and distention. Unlike opiate mixtures, moist heat has no dangers or contraindications. It is applied in the form of abdominal and perineal compresses. For these compresses to be effective, precise instructions for their preparation would be given. An abdominal compress consists of three layers; a hot moist towel over the abdomen, an electric pad or hot water bottle over the towel, and a dry towel or blanket over the pad or hot water bag. The perineal compress consists of a towel folded and rolled as shown. See the figure. It is placed in a basin or tub filled with hot water and acts as a saddle upon which the patient sits for a half hour period, several times daily, maintaining moist heat to the anal, perianal and perineal regions.

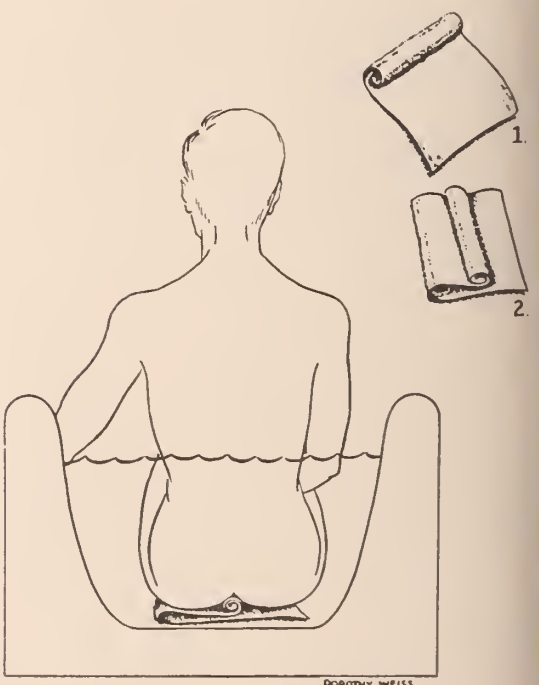


FIG. 1. THE HOT PERINEAL COMPRESS

†For those who are not as enchanted by proprietary tradenames as the author seems to be, the generic names for these drugs are: Achromycin® is tetracyclin; Azuifadine® is salicyl azo sulfapyridine; Chloromycetin® is chloramphenicol; Diodoquin® is hydroxy quinoline; Entero-Vioform® is iodo chlorhydryquin; Milibis-Aralen® is glycobiarsolchloroquine; Terramycin® is simply oxy-tetracycline; Thalamyd® is phthalyl sulfacetamine; and Sulfathaladine® is phthalyl sulfathiazole.

NAME: STOOL CHART DATE:

Day of Treatment	Morning 8	9	10	11	12	Afternoon 1	2	3	4	5	6	7	Evening 8	9	10	11	12	Night 1	2	3	4	5	6	7	Total
Mon.																									
Tues.																									
Wed.	⊗	⊗	⊗		⊗		⊗	⊗	⊗	⊗			⊗	⊗				⊗	⊗	⊗	⊗	⊗	⊗		16
Thurs.	⊗	⊗		⊗			×	⊗	⊗	×			×	×		×			×	⊗		⊗	×	×	15
Fri.		⊗	⊗			×		×	⊗		×		×	⊗	⊗				×		×	⊗			12
Sat.	⊗	⊗						×	×	⊗	⊗							×	×	⊗	⊗	⊗			11
Sun.	×	×	⊗				×		×	⊗	⊗			×		×			×		⊗				11
Mon.	⊗		×				×		×			×	⊗					×	×		⊗				9
Tues.	⊗	×					×	⊗					×	×	⊗					×					8
Wed.	×		⊗					×	⊗					×	⊗				×						7
Thurs.	×	×	⊗											×		×	⊗								6
Fri.	⊗		×					×						×		⊗									6
Sat.	×		⊗				×							⊗											4
Sun.	×	⊗												×											3
Mon.	×						×		×	⊗	⊗		×			×		×	⊗		⊗				10
Tues.	×	⊗					×			×						⊗									5
Wed.	×						×			⊗						×									4
Thurs.	×											×													2
Fri.	×							×	×	⊗					×	⊗									6
Sat.	×											×													2
Sun.	×							×	⊗																3
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Thurs.	×						×																		2
Fri.	×												×												2
Sat.																									
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CODE: × = stool. ⊗ = stool with blood.

Chart 1.

My physician would study the stool chart for a daily evaluation of the condition of the bowel. This would enable him to determine at a glance the irritability of the intestinal tract and thereby the efficacy of therapy. The "Xs" denote bowel movements. The circled "Xs" indicate gross blood. The record is simple and may be easily tabulated by the patient at home or in the hospital.

The practical aspects of the stool chart may be appreciated more easily by a discussion of a patient whose record is given here. We note that she started medical care on a Wednesday with 15 or more stools per 24 hours. All evacuations contained blood. After 10 days of treatment the chart reveals a reduction in the number of bowel movements and also less blood. On the 11th and 12th days the patient shows definite improvement; the stools number 3 to 4 throughout the day and night. On the 13th day the stools increased to 10 with an increase in the blood content. This striking change led to an investigation of the diet and it was discovered that the patient had mistakenly eaten raisins. On the 14th, 15th and 16th days the number of bowel evacuations gradually decreased to 5, 3 and then 2 in 24 hours. On the following day, however, another increase was noted. The patient said that she had family visitors who disturbed her emotionally. During the following week the convalescence progressed with only 2 or 3 stools daily. This illustrates how my physician would detect dietary or psychic irritations or sensitivity to drugs by a daily review of the stool chart.

The natural defenses of the body would be assisted but not replaced. The minimum effective dose of a drug or hormone would be used. My physician would realize that too many drugs for too long a period, or in excessive dosage, might disturb the favorable balance of the intestinal flora or the intestinal resistance to infection. He would consider their

pathogenic as well as therapeutic properties. Staphylococcic enterocolitis as a result of antibiotic therapy is an example of this disturbance. In like manner the routine and indiscriminate use of ACTH and prednisone may lead an intestinal lesion to perforation rather than healing.

In conclusion, my physician, if he is to treat successfully patients with diarrhea, must possess ample time and patience; he must detect and correct nutritional deficiencies; he must eliminate, if possible, the multiple etiologic factors; he must neutralize the infectious, toxic and nervous state associated with the diarrheal condition by the judicious and careful use of chemotherapy, parenteral therapy, antibiotics, sedatives and the cortico-steroid hormones. My physician must be rich in common sense, well informed in medical advances, and above all genuinely interested in his patient.

27 Prospect Park West

She's Got a Little List

Patients who read off their symptoms from a piece of paper like a shopping list deserve more sympathy than the doctor usually gives them. So says McCall's writer Hannah Lees. She advises her readers "What You Have a Right to Expect From Your Doctor."

One "right" she upholds is the patient's right to tick off a list of symptoms to an attentive doctor. As she explains it:

"We all are likely to have so many symptoms and have worked so hard at disregarding most of them . . . that it is easy to forget one or two . . . The logical solution is to make a list."

But the trouble is that "to almost every doctor a list brands the patient a grade A neurotic," she adds.

Miss Lees also considers the need of a patient in the menopause. "Has she a right to expect her doctor to be part mother, part priest, and part psychiatrist?" she asks. Her answer: Yes. "If he won't or can't play these roles, he is that much less good at his job."

—From the July 1959 RISS edition of *Medical Economics.*

Low Calorie Ice Cream Has Lots of Calories

"Low calorie" ice cream isn't. A comparison of regular ice cream and ice cream for reducing diets reveals a difference of only 43 calories in each serving.

According to an editorial in the *New York State Journal of Medicine* (June 1, 1959), synthetically sweetened ice cream intended for reduction diets and by diabetic patients, "is not low in calories nor in carbohydrate content."

Regular ice cream has 176 calories per serving; the fat content is 18 per cent, protein, 3.43 per cent, carbohydrate, 19.13 per cent.

Ice cream for reducing diets has 133 calories per serving; fat content is 12 per cent, protein, 4.66 per cent and carbohydrate, 21.5 per cent. Ice cream for diabetic patients has 132 calories per serving; fat content is 10 per cent, protein, 3.4 per cent and carbohydrate, 20.6 per cent.

The main difference lies in fat content; changes in protein or carbohydrate values are insignificant. Allowance must be made in recommending artificially sweetened special ice creams.

F. Clyde Bowers, M.D.

Mendham

Physiotherapy and Rehabilitation*

Treatment does not end with the stabilization of the condition. There is still another step between sick bed and work bench: rehabilitation. Physicians have too often abdicated their authority in this area—but if all doctors had Dr. Bowers' point of view, control of rehabilitation would remain in medical hands.

As defined by Dorland[1] physiotherapy implies "the use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease." One of the oldest disciplines in medicine, it was practiced extensively by Hippocrates in 400 B.C.[2] Among his many other contributions to the profession, the Father of Medicine strongly advocated the use of fresh air, change of climate, sunshine, heat and even hydrotherapy. We usually think of these modalities as recent additions to our therapeutic armamentarium. In reality they are some of the oldest means of treatment known to mankind. In recent years they have been ascribed a greater dignity because of the more highly refined technics in the administration of present day physiotherapy. This has been due in great measure to the discovery of electricity and its adaptation to supplying heat and light, *e.g.*, in diathermy machines, infra-red and ultra-violet lights. Of greater significance though, I believe, in bringing proper recognition to the importance of physiotherapy has been the enthusiasm displayed by those physicians who have interested themselves in rehabilitation.

When one speaks of rehabilitation today he must in the same breath mention physical medicine. There could be no worthwhile program for rehabilitation without physiotherapy. Treatment by physical means had been known and used for centuries; but only in the past few decades have we taken full advantage of its great potential. Probably the biggest stimulus to acceptance of this type of therapy was the plight of a great humanitarian, Franklin D. Roosevelt. Suffering from paralytic poliomyelitis, he discovered at first hand the value of all physical modalities. It is small wonder then that, through fathering the National Foundation for Infantile Paralysis, he should provide the means for the establishment of departments of physical medicine, for the purchase of equipment for these departments and for the hiring of trained physiotherapists in the treatment of this great crippler.

We must also give credit to Sister Kenny for providing incentive to a renewal of interest in the use of heat and massage. Although many of us have never subscribed to her theories, we must confess that her sincerity provoked widespread adoption of these resources. Massage was used by the ancients as we learn

*Read by invitation January 20, 1959 at the Annual Meeting of the N. J. Chapter of the American Physiotherapy Association.

1. Dorland, W. A. N.: The American Illustrated Medical Dictionary, W. B. Saunders Co., 1929.

2. Robinson, V.: A Medico-Historical Curriculum. Medical Life 139:663, Nov. 1931.

from many passages in the Bible,[3] where the "laying on of hands" was a miraculous method of healing. Nonetheless, it has been the treatment of paralytic poliomyelitis in the past two decades that has awakened in us the realization of the truly great value of massage.

THE maimed and crippled of the Second World War gave impetus to a national rehabilitation program. Under the leadership of such enthusiasts as Dr. Henry Kessler and Dr. Howard Rusk many war-time cripples have become gainfully employed. The methods then so effective for our servicemen are today being used for those who become handicapped by civilian pursuits, by disease or by birth. Sparked by President Eisenhower, the federal government is spending millions of dollars annually in rehabilitation work. Only recently did I hear Surgeon General Leroy E. Burney speak on this subject, pointing up the need for further exploration in this field.[4]

To rehabilitate a patient, it is necessary first to evaluate his disability and then institute the indicated therapy. Both evaluation and treatment can be handled best by the team approach.[5] Dr. Rusk advises that "the members of this team will vary under the conditions existing in the patient's own community, but ideally there should be family physician, neurologist, physiatrist and other medical specialists as needed, physical and occupational therapists, a speech therapist, a psychologist, a medical or psychiatric social worker, and a vocational counselor." Each of these individuals should be skilled and highly trained in his specialty. At the same time, all of their activities must be under the direction of the attending physician, who should take full cognizance of their advice and abilities.

Since this team approach is so important it would seem that some organization should exist which would provide a means of joint participation by those interested in rehabilitation. The National Rehabilitation Association has assumed the task of providing just such an organization. A New Jersey Chapter is presently being formed under the leadership of Dr. Abraham Jacobs. In a statement directed to all those interested in rehabilitation, physicians, therapists, social workers and others, he writes: "For a long time, many of us have felt the need to participate in activities which combine the various professional aspects of rehabilitation. Our organization, as part of a national organization of more than 18,000 individuals, can provide communication between different disciplines devoted to all types of rehabilitation for disabled persons of all ages."[6]

The New Jersey chapter of N.R.A. might be of inestimable help to the chairman of the Rehabilitation Commission of New Jersey in his effort to obtain a larger appropriation.[7] He notes that the number of newly accepted persons for vocational rehabilitation services has increased 49 per cent to 2002 since the program was expanded in 1956. Yet the United States Public Health Service estimates there are 6000 in New Jersey each year who need this service. The growing incidence of disability and the growth of the general population in New Jersey have out-stripped the recent program expansion. Furthermore, the per-capita expenditure for vocational rehabilitation in New Jersey places it 45th among the states. Because of the soaring costs and the limited appropriations, it means that two-thirds of our eligible needy will *not* obtain services in 1959.

REHABILITATION and physical medicine are interdependent and complemental. With the millions of people in need of rehabilitative services, the demand for more professional personnel trained in physical medicine is constant and growing greater. Recognizing this need, those of us who are interested in public health and welfare, realize that these people

3. The Holy Bible, St. James Version, Acts 28:8; Mark 6:5; Mark 7:32, Mark 16:18.

4. Burney, L. E.: "Medicine's Unfinished Business." Paper delivered at the Kessler Institute, West Orange, N. J., on December 13, 1958.

5. Rusk, H. A.: Care and Treatment of the Hemiplegic Patient. World-Wide Abstracts of General Medicine, Vol. 2, No. 1, January 1959.

6. Jacobs, Abraham: What's New in N.R.A. Rehabilitation Trends, Vol. 3, No. 8, December 1958. Page 3.

7. Holderman, Carl: Letters to Governor Meyner Quotation in Annual Report of New Jersey Rehabilitation Commission.

must be properly trained if they are to be entrusted with the treatment of human beings.

No one is more keenly aware of the necessity of the proper training and disciplining of professional workers than the physician. He is also acutely sensitive to the efforts on the part of many individuals in recent years to fragmentize the practice of medicine. There have been many problems with those who have directed their efforts to ancillary health services: nurses, pharmacists, psychologists, chiropodists, optometrists, technicians and therapists in one field or another. After a period of time, sometimes involving many years, and serious deliberation, the problem has been, in most instances, resolved.

Medicine is the oldest profession known to mankind. It has survived many threats, offering many martyrs in the process; it has withstood the encroachment of witchcraft and cultists; it has stood the test of time. During its many centuries of existence it has been looked upon as the guardian of public health. The practitioners of medicine through the ages have accepted this trust willingly and have guarded it carefully, sincerely and jealously. They have grudgingly permitted others to assume some of the responsibilities entrusted to them, but only after being convinced that the medical profession could continue to maintain control over these activities. This makes for better control of patient care, and keeps it in the hands of those most capable of administration of medical treatment. None of the ancillary medical services could survive without recognition and acceptance of parental control by the medical profession.

In the field of physical medicine, the workhorse is the physical therapist. He has a very important contribution to make to the practice of physiotherapy and his value will be greatly enhanced by proper training. To this end, it is proper that physical therapists should organize themselves into an autonomous group which can be registered, licensed and policed by their own membership. However, they should not lose sight of the fact that theirs is an ancillary service of medicine and as such must be subordinate to the medical profession. They should seek the counsel and cooperation of the physicians in any legislative endeavor. After careful analysis and deliberation, there is every reason to believe that both groups will arrive at a mutually satisfactory decision.

1 Mountain Avenue

Radioactive Test Shows Liver Damage

A new test using radioactive dye to measure the function of the liver was described in the July 4, 1959, Journal of the American Medical Association by Nordyke and Blahd.

The test, which is much simpler than older ones, opens many new possibilities in the study of liver disease and damage.

Among the conditions in which the test is used are cirrhosis, hepatitis, alcoholism and common bile duct obstructions.

Radioactive rose bengal is injected into the blood stream. The speed with which it disappears from the blood indicates the degree of liver damage or disease. The liver plays a role in removing the dye from the blood. Its disappearance is measured by a standard radiation counting device held against the head behind the ear.

Older tests using rose bengal and other substances necessitated the withdrawal of blood from the veins for checking the color of the blood. The value of these tests are restricted to liver disease without jaundice because of difficulty in reading color changes and because of possible injury to an already damaged liver by large doses of dye.

The new test circumvents these problems. Since detection of changing concentrations of dye depends on levels of radioactivity rather than color, valid results are extended to all types of liver damage despite the presence of jaundice. In addition, the minute quantities of both radioactivity and dye allow multiple tests to be done without harm.

James B. Ridley, M.D.
Englewood

Penetrating Abdominal Wound

Unusual Case in a Young Girl

An apparently superficial abdominal wound heralded rupture of the bowel and profuse mesenteric hemorrhage, following a freak accident. Swift surgery preserved the child's life.

This case is presented not only because of the unusual nature of the accident that produced the injuries, but also because it illustrates several important surgical concepts.

A nine year-old girl lives on the second floor. She was being visited by relatives. There had been a summer shower just after supper, and the storm door on the porch had been closed against the rain. Although darkness approached, no light was on the porch.

At 8:45 p.m., the tinkling bell of an ice cream vendor's cart was heard downstairs. The child begged money from her father for ice cream and ran downstairs excitedly to the vendor. In the gathering dusk, and in her child-like oblivion to everything but the ice cream, she did not see the closed storm door and crashed headlong through the glass.

She appeared to be only superficially injured. Her aunt, a physician, suspected severe trauma, and insisted that she be taken to the hospital. She reached the emergency room of Englewood Hospital at 9:15 p.m. She showed wounds of the face, left forearm and abdomen. A sliver of glass, 1 by 3 centimeters was seen protruding from a wound on the abdominal wall just below the umbilicus. This was removed and the wound, which was only 15 millimeters across, was probed with a gloved finger. This exploration yielded no information as the abdominal wall was rather thick with an abundant panniculus. It was thought that the wound did not extend to the fascia.

But the child did not look good. She was drowsy, perspiring, and content to lie quietly. When asked if she had any pain in her abdomen she agreed that she had some, but did not volunteer this information. When the abdomen was palpated she complained of pain; there was also some rebound tenderness present but these signs were mild.

Blood pressure on admission was 78/56; pulse was 135. Two units of plasma were started and within fifteen minutes her blood pressure had reached 100/70. It was then decided to explore the wound of the abdominal wall. Under general anesthesia, the skin wound was excised and found to penetrate through the rectus fascia some distance medial to the wound of entrance. The peritoneum was opened; and now the magnitude of the trauma became apparent.

The peritoneum was full of fresh blood and feces and the divided ends of the transverse colon protruded into the field. The skin towels were removed and the incision was extended upward around the umbilicus and downward to the symphysis. In addition to the trauma to the transverse colon, the mesentery was found lacerated in three places, two of which were actively spurting arterial blood. The hemorrhage was brought under control and a systematic examination of the entire intestinal tract was started. At a point about 2 inches from the ligament of Treitz, the jejunum was found to be completely transected. A short distance further, a perforation of the jejunal wall was found. No other injuries were present and no pieces of glass were found.

The small portion of jejunum between the transection and the perforation was resected and an end-to-end anastomosis was done. The mesenteric lacerations were repaired and the transected ends of the transverse colon were then uncovered preparatory to doing an anastomosis. At this point about one hour and forty-five minutes since the anesthesia had been started, the anesthetist urged that the operation be completed as soon as possible because of the poor condition of the patient.

To shorten the operation, both ends of the transverse colon were brought out at the upper end of the wound as a double-barreled colostomy. The peritoneum was drained through a stab wound in the right lower quadrant and the abdomen was closed in layers, leaving a subcutaneous drain at the lower end of the wound. Two pints of blood were given during the procedure.

Her postoperative course was uneventful after the first three days during which she ran a temperature up to 103. The colostomy began to function well on the third postoperative day and nasogastric suction was discontinued on the fourth day. She was discharged on the 22nd day with a Van Hov

colostomy cup and irrigating apparatus which she had been taught to manage by herself.

She was readmitted a month later and the colostomy was closed on the following day. She was discharged 50 days after the original accident, with all her wounds well healed, a good appetite, and normal bowel movements.

One important point illustrated by this case is the necessity of exploring *all* penetrating wounds of the abdominal wall. Military surgeons recommend exploration of penetrating wounds "from the neck to the knees." Penetrating wounds frequently appear innocuous. The history of how the wounding occurred is frequently misleading or of little value in determining the extent of internal damage. This is true also of penetrating thoracic wounds. In this case the wound, at first sight, was caused by the sliver of glass found protruding from the abdominal wall, and was apparently superficial. The fallacy of this assumption became obvious on opening the abdomen. Evidently what had happened was that the child, in going through the glass, had fallen across the lower rail of the door and had impaled herself on a long, narrow piece of glass which remained fixed to the rail. The intraperitoneal damage was caused by the patient's see-sawing efforts to free herself.

Another principle in the treatment of penetrating abdominal wounds, illustrated by this case, is the exploration of the entire peritoneal cavity. While it is unlikely that the divided jejunum would have been missed in the concentration of attention to the colonic and mesenteric wounds, it is conceivable that a small perforation of the gut might have been overlooked had not the entire small bowel been "threaded" from the ligament of Treitz to the cecum. Multiple organ injuries are the rule rather than the exception in penetrating abdominal wounds, but a systematic inspection of the contents of the peritoneal cavity is essential to finding them.

A point in symptomatology is worth emphasizing. With the contamination and blood in this child's peritoneum, one would expect severe abdominal pain, marked rebound tenderness and rigidity. These symptoms and signs were present but were misleadingly mild. It is only when we remember that shock will frequently mask symptoms that the reason for her lack of complaints becomes apparent. We are all familiar with the picture of the severely burned patient who complains only of being chilly, and we wonder why he has no pain. This analgesia is one of the beneficial effects of shock, but one of which the surgeon must be wary.

A final point must be emphasized, namely the promptness of laparotomy in suspected intraperitoneal injuries. Experience in two world wars has shown that penetrating abdominal wounds are among the most lethal injuries. Continued hemorrhage and spreading contamination combine to produce a rapid deterioration of the patient. It is not necessary to wait for the patient to recover from shock, as many will not recover until the hemorrhage and contamination are controlled at laparotomy. This patient responded well to two units of plasma, but this is not always the case. Safety lies in early operation. In probably no condition is the statement attributed to Sir Cuthbert Wallace in 1916, more valid: "It is safer to look and see than to wait and see."

Some question may be raised about doing the transverse colostomy rather than going ahead with the anastomosis of the transverse colon at the initial procedure. Dr. Frank H. Lahey, probably the greatest proponent of staged operations, once said: "You never know when you have done too much until it is too late." We possibly could have anastomosed the transverse colon at the initial procedure, but an unnecessary risk would have been added. Closure of the colostomy six weeks after the injury was a simple procedure on a healthy patient. At the initial operation it would have been a hurried procedure on a desperately ill patient and might have been enough to tip the scales unfavorably. We would not have known until it was too late.

SUMMARY

1. An unusual case of penetrating abdominal wound in a young girl is presented.

2. Several principles in the diagnosis and management of this injury are presented as illustrated by this case.

162 Engle Street

Trustees Meeting: June 28, 1959

At the June 28 session, the Board of Trustees:

—Approved the action of the President in supporting the Seventh Annual Cancer Seminar at the Presbyterian Hospital in Newark on November 22.

—Accepted a report of the Special Committee on Conservation of Vision indicating that work is going forward on the 1959 Eye Health Screening Program.

—Approved of the following suggestions to county medical societies with respect to the inter-professional medical-legal code:

1. That if they have not already adopted the inter-professional code, they do so without delay;
2. That they establish at county level a counterpart of our state Medical-Legal Liaison Committee; and
3. That through the efforts of their county medical-legal liaison committee they help to bring about the adoption of the inter-professional code by the members of the bar association of their county.

—Changed the name of the Committee on Civil Defense and Disaster Control to "Special Committee on Disaster Medical Services."

—Discussed the problem of intravenous therapy by nurses as follows:

Some confusion exists in the minds of nursing staffs concerning nurses' giving intravenous therapy. The State Board of Nurses' Examiners has not adopted the recommendations sent to it by the State Board of Medical Examiners (November 12, 1958). These recommendations were sent with the advice of Deputy Attorney General Salvest. Mr. Salvest had earlier issued a statement that nurses could give intravenous therapy under the immediate supervision of a licensed physician. We took issue with this statement, and after conferences with the State Board of Medical Examiners and Mr. Salvest, he agreed that it was not necessary for a doctor to stand by the nurse, but it was required by law that she act at the "specific direction" of a licensed physician. Following this agreement, the State Board of Medical Examiners sent the letter last November to the State Board of Nurses' Examiners, which apparently still is unwilling to accept this new statement.

In view of this, our Board of Trustees decided to ask the State Board of Medical Examiners to re-issue its November 1958 letter to the State Board of Nurses' Examiners, and that it be accompanied by a letter over the signature of Mr. Salvest stating that he accepts and concurs in the statement of the State Board of Medical Examiners. This will eliminate, it is hoped, the reluctance of the Board of Nurses' Examiners to comply with the interpretation.

—Dentists have asked that normal oral surgery by members of the dental profession be compensated for on the basis of MSP benefits, with direct payment going from MSP to the operating dentist. They pointed out that at the present time dentists are doing these procedures, but in most instances are not being paid; that in many other states payment is made by Blue Shield on the basis that the N. J. dentists seek to establish. Among the states making such direct payments are New York, Pennsylvania, and Delaware. There is no desire on the part of the State Dental Society to include general dentistry under MSP. There is no intention on their part to seek to have admitting privileges granted to doctors of dental surgery except in hospitals which already grant those privileges. An amendment to the enabling act would be necessary. On April 20, 1958, our Trustees took action which was confirmed by the 1958 House of Delegates and reiterated by the 1959 House: "The Board of Trustees of The Medical Society of New Jersey urgently requests the Board of Trustees of Medical-Surgical Plan of New Jersey to continue the limitation of its payment of eligible benefits to persons holding full licenses to practice medicine in the State of New Jersey in the present contract and in all contracts to be issued in the future."

The request was approved in principle and referred to the next meeting of the House of Delegates for action.

—Received from Dr. Costello, Chairman of the New Jersey Delegation, a report on the 1959 A.M.A. annual meeting which covered the major subjects considered by the House of Delegates. The J.A.M.A., beginning with June 20, 1959, serially issued the complete details.

Dr. Donnelly noted that this was his first visit to an AMA House of Delegates session. In comparing AMA operations and personnel with corresponding operations and personnel of The Medical Society of New Jersey, Dr. Donnelly concluded that "this Society should be very proud of its efficient and competent staff." The Chairman, with the consent of the Board, directed that Dr. Donnelly's remarks be recorded in the minutes.

Dr. Donnelly recorded his dissatisfaction with the action of the N. J. delegates in the matter of this Society's resolution favoring social security coverage for physicians. He reported that despite the mandate from our House of Delegates and oral and written instructions from the Board of Trustees, not one New Jersey delegate appeared before the reference committee to speak in favor of the resolution, and more than half of the N. J. delegates voted against the inclusion of doctors under social security. He emphasized the seriousness of such actions on the part of official delegates of this Society. He noted that the same action was true in several other states, a circumstance which in his view makes it obvious that the A.M.A.'s House of Delegates is not a representative assembly of American Medicine.

Dr. Sica stated it was not possible for delegates to attend all meetings of reference committees, and the delegates attended those considering subjects in which they had knowledge and interest.

Dr. Gardner requested that the matter of association of members of the Society with osteopathic physicians be clarified for the membership, especially in view of recent A.M.A. action. The Judicial Council has more than once published its opinions. However, the question is raised by pathologists and radiologists with respect to work referred by osteopathic physicians—are they unethical in doing work referred by osteopathic physicians?

Upon motion by Dr. Bowers—seconded by Dr. Donnelly, and carried—the Board reaffirmed the opinion of the Judicial Council "that, under the Principles of Medical Ethics, all voluntary professional association of members of The Medical Society of New Jersey with osteopathic physicians is unethical;" and directed that the Executive Officer review the entire osteopathic problem and publish a digest in the *Membership Newsletter* including references to previously published opinions, stressing that the opinion of the Judicial Council applies to all members of The Medical Society of New Jersey regardless of specialty.

Upon motion by Dr. Ware—seconded by Dr. Donnelly, and carried—the following resolution was adopted (Dr. Wegryn voting in the negative, and Dr. Buchanan and Dr. Sica not voting):

Whereas, the House of Delegates directed the New Jersey Delegates to the American Medical Association to support a resolution for inclusion of physicians under Social Security; and

Whereas, the Board of Trustees concurred and presented a resolution for such purpose; therefore be it

Resolved, that the Board of Trustees record its displeasure that the New Jersey Delegates to the American Medical Association House of Delegates, meeting in Atlantic City in June, 1959, did not give unanimous support to the New Jersey resolution urging the inclusion of physicians under social security and the end which it sought to achieve, in either the reference committee or on the floor of the House of Delegates; and be it further

Resolved, that the Board therefore directs that this circumstance be reported to the next House of Delegates of The Medical Society of New Jersey.

—1959 *Annual Meeting.* Technical exhibit income was $17,725; expenses $13,664; income in excess of expenses $4,061; reserve balance from previous year $7,917; reserve balance as of June 1, 1959, $11,978.

It is recommended that the balance in the Annual Meeting Reserve account not exceed $10,000 and that each year any excess reserve, after all expenses have been paid, be transferred to the Medical Student Loan Fund. This recommendation was approved.

—1960 *Annual Meeting.* The following were approved:

That the 1959 program schedule be followed in 1960; this recommendation has the approval of the President:

Saturday, May 14, 1960:
Afternoon—House of Delegates
Golden Merit Awards
MSP Discussion
Evening —Nominating Committee
Sunday, May 15, 1960:
All day —Reference Committees
Afternoon—House of Delegates (election)
Monday, May 16, 1960:
Morning —House of Delegates
Afternoon—General Session
Tuesday, May 17, 1960:
All day —Scientific Sections
Evening —Dinner-Dance
Wednesday, May 18, 1960:
All day —Scientific Sections

That the exhibits be opened at 1:00 p.m. on Sunday, May 15, 1960 for the convenience of the delegates, and closed at 1:00 p.m. on Wednesday, May 18, as suggested by the reference committee.

That in consideration of the criticism of having the Scientific Exhibits located on the Lobby floor at the 1959 annual meeting, arrangements are being made to locate them in the Vernon Room, Lounge floor. The dinner-dance, with the approval of the President, will be held in the Carolina Room, Chalfonte.

—*Forand Bill Hearings* (H.R. 4700). Hearings will be held in Washington, July 13 to 16, 1959. The Society is invited to send a witness to appear before the House Ways and Means Committee or to submit a written statement for the record.

Mr. Nevin pointed out that the Society's position on the Forand Bill has added significance in view of Governor Meyner's speech at the First National Conference of the Joint

Council to Improve the Health Care of the Aged in which he stated: "In the absence of a sound and reasonable alternative, I feel we must solve at least part of the problem by the American principle of insurance, as represented by the Social Security system."

The President was authorized to name representative(s) to appear before the House Ways and Means Committee in July, and the Board directed that a prepared statement be issued as representing the official position of this Society on the Forand Bill. A copy of the statement will be sent to all component societies. Also, "contact" people are requested to write their congressmen. The Executive Officer will supply these "contact" people with the Society's position on the Forand Bill.

—*Joint Council on the Aging.* Reporting for Dr. Hahn, chairman of the Special Committee on the Chronically Ill and the Aging, and the Society's official representative to the first National Conference of the Joint Council to Improve the Health Care of the Aged, Washington, D. C., June 12 and 13, 1959, the Executive Officer summarized the events of the Council meeting and the subsequent meeting of the special committee.

—*The Hawley Speech.* On May 27, 1959, Dr. Paul Hawley delivered a talk to the Group Health Insurance Conference. Title of this address was "Quality as well as Quantity." Dr. Bowers presented a resume of developments.

Following discussion, the Board went on record as being displeased with the actions of Dr. Hawley; directed that the A.M.A. Board of Trustees be notified of this Board's disapproval and be requested that the A.M.A., in turn, make known our feelings to the Board of Regents of the American College of Surgeons; and that the A.M.A. be requested to notify this Board of its action on our request.

—*Contact Lens Listing in Phone Books.* In reply to our House of Delegates resolution asking the Telephone Company to discontinue the listing "Contact Lenses—See Optometrists" in classified directories, the Telephone Company will make the following change in New Jersey classified directories. This change is similar to that being made in other Bell System directories and will provide a reference to those who fit and those who manufacture contact lenses:

OUT—Contact Lenses—See Optometrists
IN —Contact Lenses—See Lenses; Also Optical Goods-Whol. & Mfrs.; Also Optometrists; Also Physicians & Surgeons-Doctors of Medicine

—*Medical Service Administration—Public Medical Care Program.* Received and noted was a reply to the Board's inquiry as to whether MSA could serve as the fiscal agent if and when standardization of vendor payments on a statewide basis is accomplished and in operation for welfare recipients. It was reported that by formal action of the Board of Governors, MSA stands ready to utilize its facilities as the fiscal agent for such a program when it is developed.

—*Rutgers University—"Career Program."* Rutgers University is co-sponsoring, with the Newark YM-YWCA, a "Career Program" as a guidance function. The Medical Society is invited to prepare and staff an informational exhibit concerning "career opportunities in your area" and to supply pertinent data which would assist college students and selected high school seniors in long-range career planning. It was agreed that our Society participate in the program, and that the Committee on Medical Education assume responsibility for the exhibit, making use of the Woman's Auxiliary in preparing and staffing the exhibit with the understanding that the term "career opportunities in your area" means not only those concerned directly with the practice of medicine, but with all the related fields, such as nursing, medical technology, *et cetera.*

—*Blood Bank Procedures.* In reply to our inquiry relating to blood bank procedures (in behalf of the New Jersey Blood Bank Commission), the State Board of Medical Examiners stated:

1. The selection of donors, the drawing of blood and its administration to recipients are matters within the purview of the State Board of Medical Examiners of New Jersey.
2. The processing and storage of blood and/or its component parts are matters within the purview of the Hospital Licensing Division of the Department of Institutions and Agencies.

Inquiry in regard to these points should be directed to that agency.

Inquiry was made of the Department of Institutions and Agencies which replied that there is nothing in the *Manual of Standards* relating to storage, processing of blood and/or its component parts in a blood bank situation in a hospital. Inspectors do not evaluate services in connection with blood banking. The Trustees voted that the replies to the Board's inquiries be referred to the Council on Legislation, and that the Council be requested to invite pathologists and radiologists to attend a meeting to discuss the matter and to prepare proper legislation to be presented at the proper time.

—Health Care of the Aged—MSP Contract. Received from MSP was a report on the special subscription contract for those age 65 and over. This report was accepted. Its benefits would be:

(1) Surgical services as specified in the current schedule. Most fees reduced in accordance with Staff recommendations resulting in a weighted fee decrease of 19 per cent.

(2) In-hospital medical benefits per the folowing schedule:

$5.00 for the first visit
$3.00 per visit for 2nd through 30th day

(3) Anesthesia, blood transfusions, neuropsychiatric care, consultation and electro-shock as provided in the 1958 schedule of benefits.

(4) Income limits:

$2,000 per year for single subscriber
$3,000 per year for subscriber with one or more dependents

(5) Exclusion of benefits for pre-existing conditions for six months after effective date of the contract.

The contract would be offered on a one rate basis:

a.	Surgical	$0.82
b.	Medical	0.42
c.	Ancillary	0.16
d.	Operating Expense & Reserves	0.17
	Total Rate	$1.57

Recomputation of Contract Rate as follows:

1. Medical days reduced from 120 to 30.
2. Payment for medical care reduced from $7 initial visit and $4 for subsequent visits to $5 initial visit and $3 for subsequent.
3. Surgery out of hospital eliminated except for emergency surgery in connection with accidental injury. Payment for emergency surgery reduced from $40 to $35.
4. Above reductions amounted to a $0.38 per month reduction in Contract Rate.
5. Present monthly Contract Rate for Single Contract $1.61. Proposed monthly Contract Rate for Senior Citizen Contract $1.57.
6. The reduction in fees to be paid averaged 30 per cent for the fees actually reduced. However, when the fees not reduced are considered the overall weighted reduction amounts to only 19 per cent.

Disability and Social Security

The New Jersey Rehabilitation Commission will send a copy of the booklet "Disability and Social Security" to every member of The Medical Society of New Jersey within the next few weeks. This booklet will provide useful information concerning the evaluation of disability and other phases of the Social Security Act.

The booklet includes a presentation of disability evaluation guides and medical factors pertinent in evaluating disability as well as other factors that influence the extent of handicap. It provides a brief outline of the disability program.

Retain the booklet as reference material since it will prove of assistance in answering questions from your patients and in assisting them to support their claims for benefits and protection under this program.

Disability determinations are made at the Rehabilitation Commission's Disability Office, 309 Washington Street, Newark. For further information, write to Mr. Benjamin Steinleight at that office.

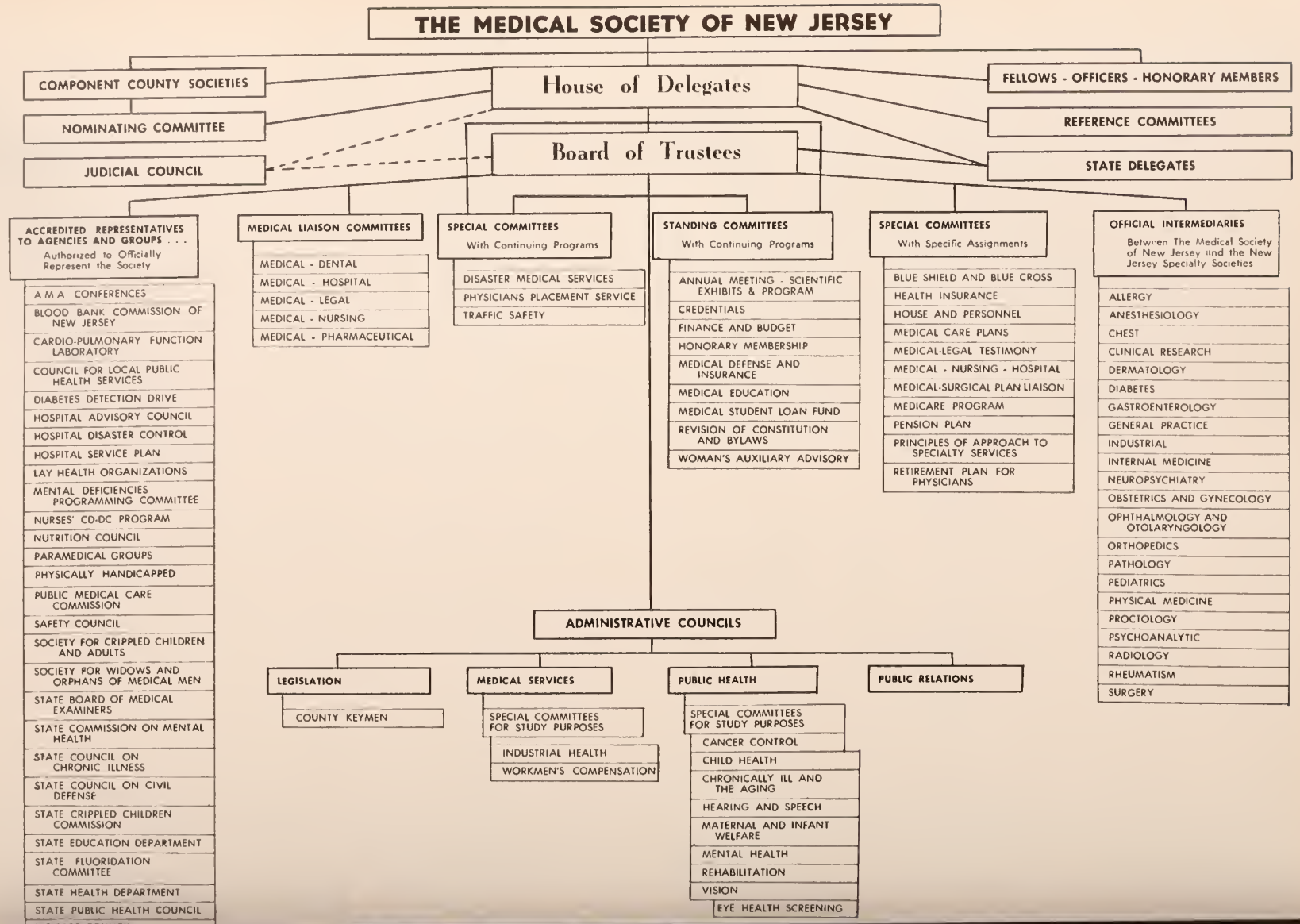
Erratum

The list of 1959 Scientific Exhibit Awards furnished to us was in error. Consequently, the list as published on page 372 of the July JOURNAL should be corrected.

Class II—New Jersey Exhibitors, Honorable Mention should read:

Physiological Cardiovascular and Pulmonary Surgery
Ralph Lev, M.D., and Lucy Aiello, M.T., Princeton Hospital, Princeton; Hunterdon Medical Center, Flemington; and The Mercer Hospital, Trenton

We regret this error and publish this correction in fairness to all concerned.


THE MEDICAL SOCIETY OF NEW JERSEY
COMPONENT COUNTY SOCIETIES
NOMINATING COMMITTEE
JUDICIAL COUNCIL
House of Delegates
Board of Trustees
FELLOWS - OFFICERS - HONORARY MEMBERS
REFERENCE COMMITTEES
STATE DELEGATES
ACCREDITED REPRESENTATIVES TO AGENCIES AND GROUPS . . .
Authorized to Officially Represent the Society
A M A CONFERENCES
BLOOD BANK COMMISSION OF NEW JERSEY
CARDIO-PULMONARY FUNCTION LABORATORY
COUNCIL FOR LOCAL PUBLIC HEALTH SERVICES
DIABETES DETECTION DRIVE
HOSPITAL ADVISORY COUNCIL
HOSPITAL DISASTER CONTROL
HOSPITAL SERVICE PLAN
LAY HEALTH ORGANIZATIONS
MENTAL DEFICIENCIES PROGRAMMING COMMITTEE
NURSES' CO-DC PROGRAM
NUTRITION COUNCIL
PARAMEDICAL GROUPS
PHYSICALLY HANDICAPPED
PUBLIC MEDICAL CARE COMMISSION
SAFETY COUNCIL
SOCIETY FOR CRIPPLED CHILDREN AND ADULTS
SOCIETY FOR WIDOWS AND ORPHANS OF MEDICAL MEN
STATE BOARD OF MEDICAL EXAMINERS
STATE COMMISSION ON MENTAL HEALTH
STATE COUNCIL ON CHRONIC ILLNESS
STATE COUNCIL ON CIVIL DEFENSE
STATE CRIPPLED CHILDREN COMMISSION
STATE EDUCATION DEPARTMENT
STATE FLUORIDATION COMMITTEE
STATE HEALTH DEPARTMENT
STATE PUBLIC HEALTH COUNCIL
WELFARE COUNCIL
MEDICAL LIAISON COMMITTEES
MEDICAL - DENTAL
MEDICAL - HOSPITAL
MEDICAL - LEGAL
MEDICAL - NURSING
MEDICAL - PHARMACEUTICAL
SPECIAL COMMITTEES
With Continuing Programs
DISASTER MEDICAL SERVICES
PHYSICIANS PLACEMENT SERVICE
TRAFFIC SAFETY
STANDING COMMITTEES
With Continuing Programs
ANNUAL MEETING - SCIENTIFIC EXHIBITS & PROGRAM
CREDENTIALS
FINANCE AND BUDGET
HONORARY MEMBERSHIP
MEDICAL DEFENSE AND INSURANCE
MEDICAL EDUCATION
MEDICAL STUDENT LOAN FUND
REVISION OF CONSTITUTION AND BYLAWS
WOMAN'S AUXILIARY ADVISORY
SPECIAL COMMITTEES
With Specific Assignments
BLUE SHIELD AND BLUE CROSS
HEALTH INSURANCE
HOUSE AND PERSONNEL
MEDICAL CARE PLANS
MEDICAL-LEGAL TESTIMONY
MEDICAL - NURSING - HOSPITAL
MEDICAL-SURGICAL PLAN LIAISON
MEDICARE PROGRAM
PENSION PLAN
PRINCIPLES OF APPROACH TO SPECIALTY SERVICES
RETIREMENT PLAN FOR PHYSICIANS
OFFICIAL INTERMEDIARIES
Between The Medical Society of New Jersey and the New Jersey Specialty Societies
ALLERGY
ANESTHESIOLOGY
CHEST
CLINICAL RESEARCH
DERMATOLOGY
DIABETES
GASTROENTEROLOGY
GENERAL PRACTICE
INDUSTRIAL
INTERNAL MEDICINE
NEUROPSYCHIATRY
OBSTETRICS AND GYNECOLOGY
OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORTHOPEDICS
PATHOLOGY
PEDIATRICS
PHYSICAL MEDICINE
PROCTOLOGY
PSYCHOANALYTIC
RADIOLOGY
RHEUMATISM
SURGERY
ADMINISTRATIVE COUNCILS
LEGISLATION
COUNTY KEYMEN
MEDICAL SERVICES
SPECIAL COMMITTEES FOR STUDY PURPOSES
INDUSTRIAL HEALTH
WORKMEN'S COMPENSATION
PUBLIC HEALTH
SPECIAL COMMITTEES FOR STUDY PURPOSES
CANCER CONTROL
CHILD HEALTH
CHRONICALLY ILL AND THE AGING
HEARING AND SPEECH
MATERNAL AND INFANT WELFARE
MENTAL HEALTH
REHABILITATION
VISION
EYE HEALTH SCREENING
PUBLIC RELATIONS

The Medical Society of New Jersey

Organization Structure

Excerpts from the Constitution and Bylaws:

No person other than a member of The Medical Society of New Jersey shall serve as a member of an administrative council or committee. A non-member may be designated as an advisor, observer, or consultant to an administrative council or committee. (IX-2)

All meetings of administrative councils and committees should be held in the Executive Offices of The Medical Society of New Jersey in Trenton, except during the annual meeting. (IX-3)

The Administrative Councils shall be:
Council on Legislation
Council on Medical Services
Council on Public Health
Council on Public Relations (IX-4)

The Standing Committees shall be:

Committee on Annual Meeting
Committee on Credentials
Committee on Finance and Budget
Committee on Honorary Membership
Committee on Medical Defense and Insurance
Committee on Medical Education
Committee on Medical Student Loan Fund
Committee on Publication
Committee on Revision of Constitution and Bylaws
Advisory Committee to the Woman's Auxiliary (IX-4)

Special committees may be created by the House of Delegates or by the Board of Trustees. They shall be appointed by the President or the Chairman of the Board of Trustees. Their specific functions and duration shall be clearly defined. (IX-19)

SPECIAL COMMITTEES

The following special committees have been appointed:

Special Committees to the Society:
Disaster Medical Services
Physicians Placement Service
Traffic Safety

Special Committees to the Council on Medical Services:

Industrial Health
Workmen's Compensation

Special Committees to the Council on Public Health:

Cancer Control
Child Health
The Chronically Ill and the Aging
Conservation of Hearing and Speech
Conservation of Vision
Maternal and Infant Welfare
Mental Health
Rehabilitation

METHOD OF OPERATION OF SPECIAL COMMITTEES

Special committees are established for intra-Society function.

They are intended to serve the Society by studying and making recommendations concerning particular matters referred to them, or officially approved for their consideration; and by carrying out approved programs.

They are not empowered to deal directly with agencies or representatives of agencies outside The Medical Society of New Jersey, except by specific permission or assignment of the Board of Trustees.

They may not commit the Society in any regard.

They are to report the results of their studies and to submit their recommendations only to the Board of Trustees or to the Administrative Council of proper jurisdiction.

They are free to call upon other committees of the Society for assistance or information in the furtherance of their investigations and studies.

They are likewise free to solicit information and assistance from specialty societies through the official intermediaries to specialty societies designated by the Board of Trustees.

If uncertainty as to procedure develops, the chairmen of special committees should consult the Executive Officer for clarification.

—Adopted by the Board of Trustees, May 17, 1959

THE ADMINISTRATIVE COUNCILS

Council on Legislation—To study and evaluate legislation—at state and national levels—proper to the interests of this Society. Other assignments in the field of legislative concern,

such as the preparation of legislation, may be given to the council by the House of Delegates or the Board of Trustees. The recommendations of the council shall be subject to the approval of the Board of Trustees before they become the official positions of this Society.

Referred items for study and report include:

Technical Services by Non-Professional Personnel
MSP Payment to Chiropodists

Chairman—C. Byron Blaisdell, M.D., Asbury Park
Vice-Chairman—R. John Cottone, M.D., Trenton

Council on Medical Services—To study and evaluate matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, to investigate matters pertaining to the economic and social aspects of medical care, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of medical service.

Current approved projects:

Establishment of a New Jersey Relative Value Schedule as a standard of evaluating professional services

Comparative study of the Optometry Act in relation to the Medical Practice Act—with the Special Committee on the Conservation of Vision

Referred items for study and report:

Hypnosis as Entertainment
Non-Participating Anesthesiologists—MSP

Chairman—Irving Klompus, M.D., Bound Brook
Vice-Chairman—Nicholas E. Marchione, M.D., Vineland

Council on Public Health—To study and evaluate all matters of interest to this Society in the field of public health, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of public health.

Chairman—Robert S Garber, M.D., Belle Mead
Vice-Chairman—John B. Fuhrmann, M.D., Flemington

Council on Public Relations—to evaluate, suggest, and—with approval—carry out programs and projects calculated to further the public relations of this Society; and to report findings and recommendations to the Board of Trustees relative to official policies, positions, and activities of this Society in the field of public relations.

Current approved projects:

Publication and distribution of the *Junio Health Hints* series to schools; *Health Hint* to the press; *Membership Newsletter;* an *Periodic Newsletter* to cooperating agencie

Preparation and publication of special news re leases and publicity materials as require from time to time in furtherance of the So ciety's business and interests

Preparation for publication and distribution o a membership guide booklet

Continuance of a consultative service in sup port of the public relations activities of com ponent societies

Encouragement of indoctrination program under the sponsorship of component societie

Responsibility for the bestowal of the annua Golden Merit Award

Maintenance of a press clipping service for th Society's public relations features, release and press notices

Press coverage for the annual meeting

Press coverage for the 1959 Eye Health Screen ing Programs

Assemble information on the services con tributed to the public by physicians in clinic in New Jersey and to publish the informa tion as a public relations project

Chairman—John F. Kustrup, M.D., Trenton
Vice-Chairman—Frederick W. Durham, M.D West Collingswood

THE STANDING COMMITTEES

Annual Meeting—Complete charge of all ar rangements, plans, and programs for the an nual meeting, and all details pertaining there to. Provide suitable accommodations for th general sessions, section meetings, House o Delegates, Board of Trustees, committee Woman's Auxiliary, and exhibits. The gener plans for the annual meeting shall be subjec to the approval of the Board of Trustees, an shall be reported to it at intervals, with complete outline at least four months in ad vance of the annual meeting.

Subcommittee on Scientific Program—T work with the section officers in the prepara tion of the section programs. All section pro grams shall be approved by the committee be fore being scheduled for presentation at th annual meeting.

Subcommittee on Scientific Exhibits—To supervise the details in connection with exhibits.

Exhibits—Divided into three classifications and be so listed in the program: scientific, technical, and educational. Authority to make and enforce rules and regulations governing exhibits and exhibitors.

Current approved projects:

A review of advances in diagnostic and clinical problems in each of the specialties be considered by the sections for a place on the program at the annual meeting directed toward the goal of keeping the general practitioner up to date on new thinking in each of the specialties, and confined to a very brief report of what is actually new and important in each of the specialty fields

Referred items for study and report:

Feasibility of opening technical exhibits to delegates on Sunday afternoon

Chairman—Jerome G. Kaufman, M.D., Newark
Vice-Chairman—Edward E. P. Seidmon, M.D., Plainfield

Chairman, Scientific Program—Edward E. P. Seidmon, M.D., Plainfield
Chairman, Scientific Exhibits—Thomas K. Rathmell, M.D., Trenton

Credentials—Review and act upon all applications for membership in component societies; report its actions in writing to component societies; provide component societies with official membership application forms; devise and adopt an official form for reporting and recording its actions.

Chairman—Marcus H. Greifinger, M.D., Newark
Vice-Chairman—Elton W. Lance, M.D., Rahway

Finance and Budget—Control the expenditure of money by officers, councils, and committees, as provided in Chapter X of the By-laws. Prepare an annual budget to be submitted to the House of Delegates. Empowered to obtain from any officer, council, or committee any necessary fiscal information.

Chairman—David B. Allman, M.D., Atlantic City
Vice-Chairman—Carl N. Ware, M.D., Shiloh

Honorary Membership—Pass upon the qualifications of all nominees for honorary membership in this Society, and report its recommendations to the Board of Trustees in accordance with the provisions of Section 7, Article IV of the Constitution.

Chairman—Aldrich C. Crowe, M.D., Ocean City

Medical Defense and Insurance—Responsible for making available optimum protection of all members, by investigating and recommending suitable insurance coverage in the fields of professional liability, accident, and health, and any other areas which shall come to be regarded by a majority of the members as necessary or desirable; act in the interest of the members in all negotiations or disputes with commercial carriers; make recommendations concerning contractual agreements to the House of Delegates or Board of Trustees; refer to the Judicial Council all complaints or accusations brought to its attention concerning the professional conduct or ethical deportment of members of this Society; report frequently to the Board of Trustees and annually to the House of Delegates concerning its activities.

Chairman—J. Wallace Hurff, M.D., Newark
Vice-Chairman—Benjamin F. Slobodien, M.D., Perth Amboy

Medical Education—to serve as the contact committee with the medical and dental schools in this State.

Current approved projects:

Cooperation with hospitals and component societies in arranging medical education programs at county or local level

Establishment and maintenance of a library of information of medical films, kinescopes, and audio-digest titles at the Executive Offices

Chairman—Sherman Garrison, Jr., M.D., Bridgeton
Vice-Chairman—Morris H. Saffron, M.D., Passaic

Medical Student Loan Fund—To administer the Student Loan Fund Program in accordance with the rules and regulations formulated by the committee and approved by the Board of Trustees.

Current approved projects:

Review and process all applications or loans and grant loans to approved applicants

Chairman—Luke A. Mulligan, M.D., Leonia
Vice-Chairman—Vincent P. Butler, M.D., Jersey City

Publication—Publication and distribution of The Journal. Empowered to edit or abstract all articles submitted for publication. Rejected articles shall be returned to their authors, with a statement of the reasons for rejection.

Chairman—Fred B. Rogers, M.D., Trenton

Revision of Constitution and Bylaws—Prepare and/or evaluate proposed revisions to the Constitution and/or Bylaws, and properly submit them to the House of Delegates.

Chairman—Louis F. Albright, M.D., Asbury Park
Vice-Chairman—Joseph M. Gannon, M.D., Plainfield

Advisory to Woman's Auxiliary—To evaluate, coordinate, and guide the Woman's Auxiliary to The Medical Society of New Jersey in all its interests and activities, subject to approval by the Board of Trustees.

Chairman—Lewis C. Fritts, M.D., Somerville

SPECIAL COMMITTEES TO THE SOCIETY

Disaster Medical Services—To initiate a program for the guidance of all component county societies in disaster medical services.

Current approved projects:

Cooperation with the State Civil Defense-Disaster Control Office

Publication of disaster medical service activities in THE JOURNAL of The Medical Society of New Jersey

Chairman—R. Winfield Betts, M.D., Medford

Physicians Placement Service—To maintain a physicians placement service and to operate in close cooperation with the component societies.

Chairman—Marcus H. Greifinger, M.D., Newark

Traffic Safety—To assist state and local governmental agencies in their programs for traffic safety.

Current approved projects:

Exploratory meeting with representatives of the New Jersey Bar Association, and the Council on Legislation concerning drivers and others under the influence of medications

Conference with representatives of the State Motor Vehicle Division concerning epileptics

Chairman—A. M. K. Maldeis, M.D., Camden

SPECIAL COMMITTEES TO COUNCIL ON MEDICAL SERVICES

Industrial Health—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Medical Services.

Current approved projects:

Education

In conjunction with the Council on Public Relations, transmit information to the members regarding the aims and purposes of industrial medicine; and cooperation with private physicians

Dissemination of industrial medical information news of any research, preventive measures, new hazards, or toxicology affecting health of employees

Collection of information on industrial health particularly by toxicology, research, and on industrial health in general

Statistical information: Collation and interpretation of statistical information including a comparison of morbidity figures in various industries

Establishment of reference sources including textbooks, journals, pamphlets, lectures, and tape recordings

Small plant medical coverage with a survey of the state situation, and encouragement of the development of small plant coverage

Cooperation with the Committees on Workmen's Compensation, Rehabilitation, and others in establishing contact with state industrial accident commission, with the state rehabilitation commission, with management groups, and with the commission on the employment of the handicapped

Chairman—Willis B. Mitchell, M.D., Toms River

Workmen's Compensation—Special committee for intra-Society function, to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Medical Services.

Chairman—Joseph A. Lepree, M.D., Elizabeth

SPECIAL COMMITTEES TO COUNCIL ON PUBLIC HEALTH

Cancer Control—Special committee for intra-Society function; to serve the Society by studying and making recommendations con-

cerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

Publication of articles on recent advances in the diagnosis and control of cancer in THE JOURNAL of The Medical Society of New Jersey

To have a cancer registry initiated in every hospital in New Jersey

To establish a statewide registry in the near future in cooperation with the Cancer Division of the State Department of Health

Chairman—John L. Olpp, M.D., Englewood

Child Health—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

Study of a simplified history and physical examination form to provide uniformity in forwarding results of physical examinations by family physicians to school or camp physicians

Study of a comprehensive program on physical education and youth health

Program for school health examinations

Referred item for study and report:

Fluoridation of local water supplies for the prevention of dental caries

Chairman—Robert E. Jennings, M.D., South Orange

Chronically Ill and the Aging—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

To activate committees on the chronically ill and the aging in all component societies

To have component committees establish liaison with all groups interested in the problems of the chronically ill and the aging and to provide leadership in their planning

Chairman—William H. Hahn, M.D., Newark

Conservation of Hearing and Speech—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

To expand the scope of the Hearing and Speech Centers now in operation and to organize new ones as needed

To promote and assist in developing facilities for the training of audiologists and hearing and speech therapists under a program leading to a doctorate

Chairman—S. Eugene Dalton, M.D., Ventnor

Conservation of Vision—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

Development of an ophthalmological plan to make available the services of diagnostic examination (including refraction) and initial treatment (including the prescription and provision of glasses) by physicians to members of unions on a funded, prefinanced basis—pilot project to be reported to the Board of Trustees

Report on the identification of school children for referral for eye care

Comparative study of the Optometry Act relative to the Medical Practice Act in cooperation with the Council on Medical Services

Preparation of a series of informative articles for the guidance of physicians on the subject of the status of optometry and the A.M.A. position in regard to optometry

Chairman—Charles E. Jaeckle, M.D., East Orange
Vice-Chairman—Alfonse A. Cinotti, M.D., Jersey City

Maternal and Infant Welfare—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

Review and classification of infant deaths

Review and classification of maternal deaths

Publication of cases, selected for their educational value, in THE JOURNAL of The Medical Society of New Jersey

Chairman—John D. Preece, M.D., Trenton

Mental Health—Special committee for intra-Society function; to serve the Society by studying and making recommendations concerning particular matters referred to it, or officially approved for its consideration; to carry out approved programs; to report the results of its studies and to submit its recommendations to the Council on Public Health.

Current approved projects:

Discussion of the proposed movement of the State Division of Constructive Health to initiate diagnostic centers for mentally retarded children in specific locations throughout the state by utilizing the resources of general hospitals

Study of a suggestion that certain psychiatri disease entities be considered reportable

Study of the relationship between psychia trists, psychologists, and psychiatric socia workers

Study of the problem of mental health of th aged, particularly the increasing aged popu lation in mental hospitals

Cooperation with the New Jersey Neuropsy chiatric Association in Graduate Educatio

Chairman—Vincent P. Mahoney, M.D., Camden

Rehabilitation—Special committee for intra Society function; to serve the Society by study ing and making recommendations concernin particular matters referred to it, or officiall approved for its consideration; to carry ou approved programs; to report the results of it studies and to submit its recommendations t the Council on Public Health.

Current approved projects:

Devotion of one meeting in each component so ciety each year on the subject of rehabilita tion

Investigation and survey of patients and treat ment facilities available throughout the stat

To take such steps as may be necessary an without cost to the Society, for the compila tion and publication of a directory on state and county basis of local rehabilitatio services

Chairman—Elmer J. Elias, M.D., Trenton

Do You Have Any Cases of Sjogren's Syndrome?

Your cooperation is requested in a study of Sjogren's syndrome recently initiated at the National Institutes of Health, Bethesda, Maryland. The cardinal manifestations are keratoconjunctivitis sicca, diminished salivation, salivary gland enlargement and arthritis. The purpose of the study is to define the clinical, histologic and immunologic spectrum of the syndrome. Patients are sought who manifest only dryness of the eyes and filamentary keratitis or xerostoma, as well as those who manifest the entire syndrome. Patients with scleroderma, systemic lupus erythematosus or periarteritis nodosa complicated by Sjogren's syndrome will also be admitte

Accepted patients will be studied for sever weeks. An individualized therapeutic progra will be instituted for each patient. Upon com pletion of their study, patients will be re turned to their referring physicians who wi receive a complete summary.

Physicians interested in referring indivi ual patients should write or telephone:

DR. KURT J. BLOCH
National Institute of Arthritis an Metabolic Diseases
Bethesda 14, Maryland
(OLiver 6-4000, Ext. 2612)

Obituaries • • •

DR. JOSEPH ALBANO

One of North Jersey's veteran physicians died on July 15 with the passing that day of Dr. Joseph Albano at the age of 82. Born in Italy, he received his M.D. at the University of Naples in 1902 and was licensed to practice in New Jersey in 1903. He was an organizer of the Columbus Hospital in Newark. He was a family doctor and served as medical adviser or consultant to numerous organizations. A Golden Merit laureate of The Medical Society of New Jersey, he was also decorated by the Italian government in 1952 with the coveted "Star of Italy" award. He was a long-term member of our Essex County Medical Society.

DR. ELMORE G. BRITTAIN

News has come from Clearwater, Florida of the death there, at the age of 64 of Dr. Elmore G. Brittain who, for many years, practiced in Bound Brook. A graduate of the Baylor University School of Medicine (class of 1917), Dr. Brittain served in the medical corps of the Army in both World Wars. He was an attending surgeon, later an Emeritus Surgeon to the staff of the Somerset Hospital. He was an FACS and was active in the affairs of the Somerset County Medical Society. He died of a coronary attack on June 27, 1959.

DR. EDMUND C. HESSERT

On Sunday, July 5, Dr. Edmund C. Hessert, Sr., died suddenly of a heart attack on the grounds of the Seaview Country Club in Absecon. Dr. Hessert was born in Oaklyn, N. J. in 1902 and was identified with southern New Jersey all his professional life. In 1924 he was graduated from Hahnemann Medical College and then did postgraduate work in gynecology at the University of Pennsylvania. He was appointed to the faculty of his alma mater and eventually became head of the gynecology department there. He also became chief of gynecology at the West Jersey Hospital in Camden. He was an FACS, an FICS and active in the New Jersey Obstetrical Society.

DR. A. ANDREW KENNEDY

Dr. A. Andrew Kennedy of Clifton died on July 15. Born in Hazleton, Pennsylvania in 1893, Dr. Kennedy was graduated in 1923 from the medical school of Temple University in Philadelphia. After interning and practicing in Pennsylvania, he came to New Jersey in 1930 and lived in Clifton during most of the period since then. He was on the staff of the Veterans Administration Hospital in East Orange and was there at the time of his death. In World War I, Dr. Kennedy served in enlisted status and on being mustered out in 1919, he entered medical school. In World War II he served in the Navy rising from lieutenant to full commander. Dr. Kennedy was active in the affairs of the Passaic County Medical Society.

DR. LINDLEY H. LEGGETT

While vacationing in Maine, Dr. Lindley H. Leggett, Jr., of Westfield, died suddenly on July 22. Dr. Leggett, who was 65 at the time of his death, was one of New Jersey's pioneer pediatricians. Born in Brooklyn he was graduated in 1918 from the New York Medical College. He moved to, and became active in Union County affairs. He was a member of the Westfield Board of Health. He was long affiliated with the Muhlenberg Hospital in Plainfield, rising through all ranks and became consultant in pediatrics there last year. He was a well-known photographer, active in the Westfield Photographic Society. He was also a trustee of his church.

DR. CHARLES SIRKEN

After a long illness, Dr. Sirken died on the fourth of July, 1959. He was born in Jersey City in 1894, graduated from Bellevue in 1917, and served in the medical corps of the Army during World War I. He was identified with the Christ Hospital all his professional life. He interned there, he was on its staff in many capacities and he died there. He was secretary to the medical staff for many years and from 1945 through 1947 he was president of the medical board of that hospital. He was the founder and the first president of "The Clinicians," a Hudson County medical group.

DR. GEORGE W. TYRRELL

Dr. George W. Tyrrell died on July 1 at the grand old age of 89. He was one of Middlesex County's colorful practitioners. He served the people of Perth Amboy for over 60 years. Dr. Tyrrell was born in New Jersey and prior to entering medical school he worked as a clerk, stationer, newspaper carrier, and railroad man. In 1893 he received his M.D. at the College of Physicians and Surgeons in Baltimore. He did graduate work in Europe in 1895. All his professional life he was affiliated with the Perth Amboy General Hospital. Dr. Tyrrell was a pioneer in radiology and was a charter member of the Roentgen Society of America. He was an Emeritus Member of the Middlesex County Medical Society and The Medical Society of New Jersey.

Announcements • • •

Symposium on Antibiotics

Every practitioner will find something practical in the colloquium on antibiotics Wednesday, September 23, in Newark at the Essex House, Lincoln Park. The meeting will run from 10 a.m. to 4:30 p.m. Full program may be obtained from Dr. R. R. Chamberlain at 30 Lenox Place, Maplewood, N. J. Luncheon will be served gratis to all physicians attending the session. The program is sponsored by the New Jersey Academy of General Practice in conjunction with Wyeth Laboratories. All aspects of antibiotic usage will be reviewed.

Radio Seminars for Doctors

Each Tuesday at 12:30 (noon) physicians who can tune in on WHYY (frequency modulation 90.9) will be able to hear a practical series of seminars sponsored by the Pennsylvania Hospital. Doctors in hospitals in Delaware will be able to talk back and ask questions, so that the listening physician will not only hear the lecture but will also have the benefit of hearing discussion. The topics include:

Oct. 6 Antibiotics
Oct. 13 After-care of malignancies
Oct. 20 Toxemias of pregnancy
Oct. 27 Diuretics in heart disease
Nov. 3 Steroid therapy of hypersensitiveness

For a full program, write to Dr. F. M. Richardson, Coordinator of Education, Pennsylvania Hospital, 801 Spruce St., Philadelphia 7, Penna.

Chest Disease Course

The American College of Chest Physicians announces a course in "Diseases of the Chest" for the Park Sheraton Hotel in New York City, November 9 through 13. Tuition is $100 and worth it. Obtain further details from American College of Chest Physicians at 112 East Chestnut Street, Chicago 11, Illinois.

Medical Course for Lawyers

The Institute for Practicing Lawyers announces a course in medicine for attorneys to be held Wednesdays from October 7, 1959 through January 7, 1960. The program will run from 7:15 to 9:15 p.m. and all meetings will be at the Martland Medical Center at 65 Bergen Street, Newark. The program:

1959

Oct. 7—Medicolegal aspects of head injury. Dr. William Ehrlich
Oct. 14—Spinal cord injury. Dr. Harold Somberg
Oct. 21—Back injury. Dr. Sidney Keats
Oct. 28—Injuries of the upper extremities. Dr. Anthony DePalma
Nov. 4—Injuries of the lower extremities. Dr. Jarvis Smith
Dec. 2—Injuries of the chest. Dr. Kenneth Smith and Dr. T. J. Ormsby
Dec. 9—Medicolegal aspects of heart disease. Dr. Jerome Kaufman
Dec. 16—Forensic dermatology. Dr. John Hunt and Dr. Bart James

1960

Jan. 6—MedicoLegal aspects of neoplastic disease. Dr. Leonard Ellenbogen
Jan. 13—Evaluation of disability. Dr. Fulton Massengill and Dr. Philip Willner
Jan. 20—The Autopsy. Dr. Edwin L. Albano
Jan. 27—Forensic psychiatry. Dr. Henry Davidson

For further information, write to Mr. Arthur L. Abrams, 744 Broad Street, Newark 2, N. J.

Proctology Meeting

Thursday evening, October 8, has been set aside for a symposium on general proctology at the New York Academy of Medicine on Fifth Avenue. Topics to be covered: (a) Removal of foreign bodies from rectum; (b) postoperative colitis; (c) carcinoids of the rectum; (d) malignancy in *fistula in ano*. Details may be obtained from Dr. Norman Frennd of 163 Ocean Avenue in Brooklyn.

Symposium on Infant Feeding

On Tuesday, October 27, at the Cornell Medical Center in New York City, there will be a symposium on infant feeding. The protein nutrition of infants is the theme of the morning session. In the afternoon there will be a panel discussion and in the evening a discussion of appetite regulation. Full program is obtainable from Council on Foods and Nutrition, 535 North Dearborn St., Chicago 10, Illinois.

Conference of X-ray Technicians

The Traymore Hotel in Atlantic City, is the site of the Conference of X-ray Technicians, November 6, 7 and 8.

The program includes scientific papers, panel discussions and refresher courses. The latter will include "Fundamentals of X-ray," taught by Mr. George Nixon, Chief Technician, Columbia Presbyterian Medical Center, New York City, and "Terminology," taught by Mr. Robert Baseman, Chief Technician, St. Vincent's Hospital, New York City. The material to be covered will be of interest to both students and technicians.

Registration starts at 2 p.m., Friday, November 6th. That evening there will be a get-together; round dances and an old fashioned square dance where you will meet old friends and make new ones. The outstanding social event of the conference will be the banquet on Saturday evening. The conference will terminate with a business meeting on Sunday morning.

Translation Service Available

The JOURNAL is frequently asked where to obtain swift, confidential and accurate translation services. We have learned that the Princeton Translators are available for medical and scientific works. Write to Director, The Princeton Translators, 135 Nassau Street, Princeton, N. J.

Research Contributions to Clinical Practice

The New York Academy of Medicine announces an annual Postgraduate Week, October 5 through October 9. Theme of this year's seminar is "Research Contributions to Clinical Practice." Each day there is a panel meeting at 4 p.m. and lectures at 8:30 p.m. All aspects of day-by-day medical practice are covered. For details, write to Postgraduate Secretary, Academy of Medicine, 4 East 103 Street, New York 29, N. Y.

Mental Retardation Film Available

If you are looking for an interesting educational film for parents, civic or school groups you may obtain a 30-minute black and white sound film entitled *Into the Sunlight*. No charge except postage. This deals with mental retardation in a hopeful, yet realistic way. For details write to Public Relations Officer, The Training School, Vineland, N. J.

Encephalitis Bibliography Available

The National Library of Medicine has for free distribution a bibliography on encephalitis. Write to Acquisition Division, National Library of Medicine, 700 Independence Avenue, S. W., Washington 25, D. C.

Medicolegal News Letter Available

The Cudahy Publishing Company at 6141 North Cicero Avenue, Chicago 46, Illinois, publishes a monthly news-letter on medicolegal matters. At an annual subscription of $10, this brochure gives down-to-earth, practical, medicolegal data especially written for physicians.

County Society Reports • • •

Gloucester

On May 21 the final meeting of the 1958-59 year was held. The Society's Auxiliary were guests and the place of the meeting was the Woodbury Country Club.

President S. Thomas Camp, M.D., asked Dr. Laurusonis to introduce our speaker, Harry R. Draper, M.D., a staff member of the Benjamin Franklin Clinic.

Dr. Draper's topic was "Psychiatric Emergencies." He recommended certain books for the general practitioner. Discussion of needs locally was introduced by Dr. Laurusonis. Dr. Draper was given a rising vote of appreciation.

A business session followed with reports of committees and trustees.

A. Guy Campo, M.D., Chairman of the Nominating Committee reported. All nominees were unanimously elected as follows:

President—Dorothy M. Rogers, M.D.
Vice-President—Thomas F. Flynn, M.D.
Secretary—F. M. Brower, M.D.
Treasurer—George R. Booth, M.D.
Reporter—William D. Kehler, M.D.
Historian—R. C. Puff, M.D.
Trustees—S. T. Camp, M.D., 3 years; C. I. Ulmer, M.D., 2 years; J. E. Wentzell, M.D., 1 year
Censors—F. G. Wandall, M.D., 3 years; J. G. Kehler, M.D., 2 years; H. Wright, M.D., 1 year
Delegates—L. J. Collins, M.D., 3 years; J. G. Kehler, M.D., 2 years; C. I. Ulmer, M.D., 3 years; A. G. Campo, M.D., 2 years; J. J. Laurusonis, M.D., 1 year. Alternates—T. F. Flynn, M.D.; S. T. Camp, M.D.; W. T. Beall, M.D., C. L. Samuelson, M.D., and D. M. Rogers, M.D.
Nominating Delegate for 1 year—L. K. Collins, M.D. Alternate—J. J. Laurusonis, M.D.
Executive Secretary—Marian F. Chew

Members and guests enjoyed a collation with tempting food, an informal question and answer period, and pleasant social contacts.

DOROTHY M. ROGERS, M.D.

Reporter

Hudson

With Dr. John J. Bedrick presiding the annual meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on May 5.

Annual reports of the Treasurer, Membership Committee, and Board of Trustees were read and accepted.

Dr. Charles E. Rosen, President-elect, succeeded to the office of president without further process. On motion the secretary cast one vote for the candidates selected by the Nominating Committee and announced at the March and April meetings. Officers for the administrative year of 1959 - 1960 are: President—Dr. Charles E. Rosen; President-Elect—Dr. Charles A. Landshof; Vice-President—Dr. Nathan J. Plavin; Secretary—Dr. Matthew E. Boylan; Treasurer—Dr. Clement M. Jones, Reporter—Dr. Roy A. Morrow.

The following were elected to membership: Drs. John T. Harrigan, Natalia Koropecky and Myron Soled, all of Jersey City.

Drs. Harry C. Cody, William W. Maver and Albert D. Greene, who had already received the Golden Merit Award for fifty years of practice at the State Society meeting were honored by our County Society. The congratulations of the Society were voted to these men.

Guest speaker of the evening was Dr. Stuart S. Stevenson, Professor of Pediatrics, Seton Hall College of Medicine. His presentation was entitled "Differential Diagnosis in the Newborn Infant."

Following the conclusion of the scientific session and business meeting, a collation was served.

ROY A. MORROW, M.D.

Reporter

Monmouth

The annual summer outing of the *Monmouth County Medical Society* was held at Old Orchard Country Club on June 24. Dr. William D'Elia, Outing Chairman, acted as toastmaster. The year's activities were summarized by Dr. David McCreight, the out-going president. As in-coming president, Dr. Lester Barnett presented Dr. McCreight with an inscribed gavel in appreciation for "a job well done."

The following were elected to Active membership: Drs. Edward G. Allegra, Red Bank; Joseph W. Schauer, Jr., Farmingdale; Justin C. Terra, Keyport; Myra R. Zinke, Matawan. Associate membership was granted to the following: Drs. Alexander C. Baret, Long Branch; Emilie V. C. Chan and Morris Reby, Marlboro; Raymond L. Cuneff, Jr. and Victor J. Witek, Red Bank.

The golf tournament which preceded the dinner meeting saw the following winners: Drs. Joel Feldman, low gross; Joseph Bassone, Geriatric Trophy; and Theodore Schlossbach, Calloway winner.

The meeting was well attended and continued to be its usual success.

DONALD W. BOWNE, M.D.

Reporter

Civil Defense Items • • •

CASUALTY CARE TRAINING

Our Committee on Disaster Medical Care, AMA, held a day-long program on mass casualty care. The council also sponsored a luncheon for the conferees on June 6. This was presented entirely by the Army Medical Service as a one-day version of the Army's regular one-week course. Copies of lectures usually given at Walter Reed Army Institute of Research and at the Army Medical Service School, Brooke Army Medical Center were distributed to the conferees. The session included two excellent exhibits on field equipment for early survival care and on the effects of radiation. Those of us who attended feel that it was a day well spent. We were encouraged by the positive approach and the feeling of hope in the resolution of foreseeable problems instilled by all the excellent speakers.

SHELTERS

Office of Civil and Defense Mobilization Bulletin MP-15 provides guidance to physicians, engineers, architects, contractors and the general public in planning shelters for fallout protection. This publication is available at State Civil Defense headquarters. If new construction is contemplated, it might prove advantageous to consult these manuals.

MANAGEMENT OF MASS CASUALTIES

The following courses in the management of mass casualties will be given during the fiscal year 1960:

September 14 to 19, 1959 and February 15 to 20, 1960 at Walter Reed.

At the Army Medical Service in Fort Sam Houston, Texas; November 30 to December 4, 1959; February 15 to 19, 1960; April 25 to 20, 1960; and June 13 to 17, 1960.

Civilian medical applicants are requested to submit their names three months in advance of the date selected.

TRAINING FILMS

Navy films for training in casualty care for use by county medical and dental societies have been purchased by the State Division of Civil Defense and are available on loan. They are:

MN-7477—Sucking Wounds of the Chest
MN-7470—Wounds of the Abdomen
MN-7335—Blood, Plasma and Serum Albumin in Shock
MN-7484—Artificial Respiration
MN-9375-c—Serologic Technic and Venipuncture
MN-7469—Cricothyroidotomy

Rescue Breathing—a 35 minute colored film instructing in mouth to mouth breathing has also been obtained.

These excellent films may be used in conjunction with the naval training mannikin—two of which have also been purchased by the State Division of Civil Defense and described in our May bulletin.

EMERGENCY HOSPITAL PROGRAM AS OF JUNE 15, 1959

State	Delivered as of 5-31-59	Being Processed as of 6-15-59	Purchased Under Federal Contribution Program	Loaned for Training
New Jersey	41	10	3	1
New York	0	0	200	0
Region* I	139	18	221	6

The balance allotted to Region I is 66 hospitals.

*This Region includes New Jersey, New York and the New England States.

QUOTES TO NOTE

"The Military Operations subcommittee has contended and recent authoritative studies have confirmed, that achieving protection from the effects of thermonuclear weapons is by no means a completely hopeless task, as so many people seem to believe. As devastating as thermonuclear weapons may be, their lethal effects, particularly those of fallout radiation, can be substantially reduced by nonmilitary defense measures prepared in advance of an attack. A nation ravaged by nuclear assault can still survive, sustain itself, and restore viable economic life, provided the problems of civil defense planning and preparation are squarely faced, carefully analyzed, and systematically resolved by effective Government action."

From *Civil Defense in Western Europe and the Soviet Union,* Fifth Report by the Committee on Government Operations, House of Representatives, Report No. 300, p. 6, (1959).

DISASTER INFORMATION

Be prepared before disaster strikes. Make sure that the citizens in *your* community carry important health information with them at all times. AMA has two health pieces which could be most useful in emergency.

The *Personal Health Information Card* is a wallet-sized card for the individual. It contains space for address, next of kin, family doctor, health insurance policy numbers, names of diseases (*e.g.*, diabetes), blood type, Rh factor, vaccinations, surgery, recent illnesses and special instructions.

Your Family Health Record is a booklet which has space for names of all members, family history, immunizations, checklist of diseases, physical examinations, illnesses and health and accident insurance information.

Both the card and the booklet may be obtained from AMA for distribution to your colleagues engaged in civil defense activities and to others in your community.

Book Reviews • • •

Obstetrics and Gynecology. By J. R. Willson, M.D., C. T. Beecham, M.D., Isador Forman, M.D. and E. R. Carrington, M.D. St. Louis 1958. Mosby. Pp. 605 with 267 illustrations. ($10.75)

The test of teaching material is whether it teaches. This book was written inductively—that is it came out of actual teaching experience at the medical school of Temple University. It fills a comfortable niche between the stream-lined "outline" which gives facts and dogmas without encouraging thought, and the encylopediac treatise in which you can't see the trees for the forest. This book is particularly good as a reference work for general practitioners. It covers standard health examinations, diagnostic technics, menstrual abnormalities, sterility, normal and abnormal pregnancies, obstetrical anesthesia, obstetrical technics, care of the newborn, and the whole spectrum of medical and surgical gynecology. The illustrations are superior in their clarity, and while sometimes overschematic, are always accurate. More advanced or highly specialized technics are often omitted, but indications for calling for specialized help are clearly spelled out.

VICTOR HUBERMAN, M.D.

How to Live with Diabetes. Henry Dolger, M.D. and Bernard Seeman. New York 1958. Norton. Pp. 192. ($3.50)

It seems a long way from the days when the patient was told only that "doctor knows best." Today, the fashion is to give the patient charts, glossaries and reading matter about his illness. This book, co-authored by a professional writer, tells the diabetic a good deal about his condition. There are special sections on children and women patients. The medical author seems enthusiastic about an oral antidiabetic which he identifies by trade-name. He also recommends one brand of insulin syringe—actually specifying the manufacturer. The style is interesting and the authors include a fair amount of human interest material. Unless the practitioner disapproves of Dr. Dolger's enthusiasm for his favorite oral product, he will find this a helpful book to put in the hands of his more sophisticated diabetics.

ULYSSES M. FRANK, M.D.

A Way of Life and Selected Writings of Sir William Osler. Edited as a Centenary Tribute by the Osler Club of London, with the help of W. W. Francis, M.D. New York 1958. Dover Publications, Inc. Pp. 278, with 5 illustrations. ($1.50)

By special arrangement with the Oxford University Press, its 1951 volume, *Selected Writings of Sir William Osler*, is now made available in paperback edition by Dover Publications.

Although Sir William Osler died forty years ago his lasting influence on senior medical men still testifies to the rare and personal quality of his leadership. I often heard my physician-father speak of Dr. Osler. Osler greatly stimulated the intellectual life of medicine in his time. Through the Pulitzer Prize-winning biography by Dr. Harvey Cushing and recent reprintings of Osler's works such as this paperback, one can recapture the knowledge, philosophy and wisdom of this outstanding man.

In an introduction to this book, Sir Geoffrey Keynes, the eminent British surgeon, writes: "The generation that knew Osler is quickly passing and with it must pass the memory of his living presence. His Text-book of Medicine, although it can remain a pattern of style in medical writing like every other text-book, cannot, with the advances of the Art and Science, be for long an active influence. Osler's memory cannot, indeed, l

erved better than by a reading, or a re-reading, f his addresses and essays." This selection of favrite and lesser known writing will help make sler's influence permanent.

The committee which selected these articles did ot aim to present their patron saint as a patholoist or internist, but to depict him as speaker and ssayist telling of his concern with the history of edicine and of physicians and of his love of ooks. The first essay, "Creators, Transmuters, nd Transmitters," written for a Shakespeare exibition in 1916, is hard to come by. Osler's three tters to his house physicians describing his visits o continental hospitals and towns in 1890 are here ollected for the first time. "A Way of Life," and A Student Life," are his best known addresses; ssays on Sir Thomas Browne and Robert Burton f "Melancholy" fame tell of two English writers ho were Osler's special heroes.

Other gems among the sixteen essays in this ollection are: "Books and Men," "The Old Huanities and the New Science," "Teaching and hinking," "The Growth of Truth," "Gui Patin," The Young Laennec," "Illustrations of a Bookorm," and, "The Collecting of a Library." All old, this book affords a fine sample of *Osleriana* in s 278 pages.

Writing in 1930, Abraham Flexner said this: The very intensity with which scientific medicine s cultivated threatens to cost us at times the melow judgment and broad culture of the older genration at its best. Osler, Janeway, and Halsted ave not been replaced. As a matter of fact, scintists—medical as well as other—owe something o themselves as human beings, something to the raditions and heirlooms of history, something to he unity and integrity of all science . . . Even hough a faculty of medicine trains mainly practitioners, too often vocational practitioners, the oots of medicine go deep into cultural soil; its deals are fundamentally humanistic, scientific, and hilosophic."

Osler in a paperback edition is a publishing vent—making more widely available the wisdom rom his pen. Here the reader can find an inspiraion for the classics and the Bible, a feeling for he humanities and the beauty of literature, and he relationship between science, philosophy and istory. This durable, yet inexpensive, volume has good chance to get to those for whom Osler's on-technical writing was meant. Here for the interested reader are masterpieces that will continue o inspire.

Fred B. Rogers, M.D.

The Technic and Practice of Psychoanalysis. By L. J. Saul, M.D. Philadelphia 1958, Lippincott. Pp. 245. ($8.00)

In compact and workmanlike fashion, Dr. Saul overs the technic of psychoanalysis. This is strictly midcentury book, with no fetishistic devotion o the compulsive rituals of traditional analysis. n spite of the author's tendency to overdocument there are footnotes on almost every page—or at least it seems that way when you read the book), Dr. Saul is not adverse to variety and versatility in technic. He includes something on what he calls "non-interview material" (an unusual item in a book on psychoanalysis) as well as the expected chapter on how to begin an analysis and on how to end one. Many practical points are taken up. The theoretical material runs to only 40 pages, but is adequate for this handbook. There is a good chapter on failures and a usable index.

Abraham Leff, M.D.

Medical Terminology Simplified. Louis L. Perkel, M.D. Springfield, Illinois 1958, Charles C Thomas. Pp. 103. ($3.85)

It's like tasting salted peanuts. You dip into this book and find out about one medical word, and another catches your eye; and before you know it, you've gobbled them all. Technical terms are the tools of our communication, and a physician, medical secretary, nurse or hospital clerk has to know the tools and keep them sharp. Dr. Perkel includes lists of roots, prefixes and suffixes. He shows how to break down a word into its components. He offers examples and suggests exercises. He packs a peck of precise data into a small place for a small price. Perhaps some might disagree with his including D.C. as a label for a member of the healing profession, but he is only following the state law at that. Any medical student, medical secretary or nurse will do better work for studying this slim volume. And it won't hurt doctors any.

Henry A. Davidson, M.D.

Atlas of Technics in Surgery. John L. Madden, M.D. New York 1958. Appleton-Century-Crofts. Pp. 648. ($30.00)

This huge volume follows the recently popu'ar practice of depending on contributing authors for supplementation and diversification. It starts with chapters on pre-operative care, postoperative care and anesthesia. It then easily glides into a discourse on the incisions used in general surgery.

Following these highly informative chapters, the book devotes itself to a detailed description of all of the operations of general surgery. At the end of each operation, the contributing authors are utilized as discussants. This is followed by a liberal bibliography on controversial aspects of each subject.

This is an atlas, and the illustrations are profuse and in meticulous detail, depicting many of the intermediate steps in each operation. The illustrations are unusual in that they were made by an artist who was present at each operation at least once and probably many times. The illustrations are done in carbon half tones and on an antique

The next aim of therapy is to make the patient comfortable. One of the primary problems is to clear the tracheobronchial tree of thick, tenacious sticky secretions. A saturated solution of potassium iodide is given in a dose of 15 drops in a half glass of water three or four times a day, to make it easier for the patient to expectorate. Cough mixtures containing codeine, morphine, or meperidine (Demerol) hydrochloride, should be avoided. Meperidine, especially, dries secretions and increases the difficulty of clearing the tracheobronchial tree. If bronchodilators are given, they should be given locally and systemically.

TYPES OF TREATMENT

Sedatives. If the patient can be made to breathe comfortably, he does not need sedatives, which depress the respiratory center. Avoid the use of morphine and codeine. Phenobarbital in a dose of 30 to 60 mg. or chloral hydrate in a dose of 1 to 3 gm. will give mild sedation without respiratory center depression.

Oxygen Therapy. Oxygen therapy should be used in the patient with emphysema who is acutely ill with a respiratory infection if hypoxemia is a significant problem. It is useful in the late stages of the disease to make the patient more comfortable.

Breathing Exercises. The success of breathing exercises depends on the enthusiasm of the physician. Many patients use these exercises faithfully for a while, and then abandon them.

Intermittent Positive-Pressure Breathing. The initial enthusiasm for this device has now worn off, although it is helpful in some cases.

Steroid Therapy. Steroids are of little value in the treatment of primary emphysema. Patients with bronchial asthma respond well to steroid therapy. This re-emphasizes the importance of discovering the cause of the patient's emphysema. If emphysema is secondary to other lung diseases, the primary treatment should be aimed at the underlying lung disease.

Pneumoperitoneum. The administration of air into the peritoneal cavity to raise the diaphragm and improve the expansion of the lung has been advocated but there is little objective evidence to support it.

Artificial Ventilation with a Respirator. The respirator does have a definite place in the treatment of patients with respiratory acidosis. It is most useful in patients who have severe emphysema and an acute infection. One disadvantage is that many patients have great difficulty in adjusting their normal ventilation to that of the respirator. Adequate respiratory care requires trained physicians, nurses, and attendants.

Smoking. Some workers have suggested smoking is a cause of pulmonary emphysema. However, severe emphysema does occur in a few patients who have been non-smokers. This point needs further study. We urged patients to stop smoking.

Surgery. Surgical removal of part of the lung in emphysema has been recommended. The theory is that if a portion of the lung is cystic and over-distended it prevents proper function of adjacent normal lung tissue. This has been demonstrated in patients with localized cysts of the lung. In the generalized form of the disease, however, we do not recommend surgical removal of parts of the lung.

SUMMARY AND CONCLUSIONS

It is important to differentiate primary emphysema from emphysema secondary to other type of lung disease. When emphysema is secondary to asthma or other lung disease, therapy should be directed to the primary disease. When emphysema exists as a primary disorder, the aims of therapy are to preserve lung tissue, keep the patient active and make him comfortable.

Preservation of lung tissue is done by treating all respiratory infections vigorously. The patient with emphysema may exert himself to the point of dyspnea. He can be made more comfortable by means of properly selected drugs. The responsibility of the physician is to give the patient clear understanding of this disorder and to help him regulate his life. In emphysema, as in other diseases, the patient needs a physician and not a gadget.

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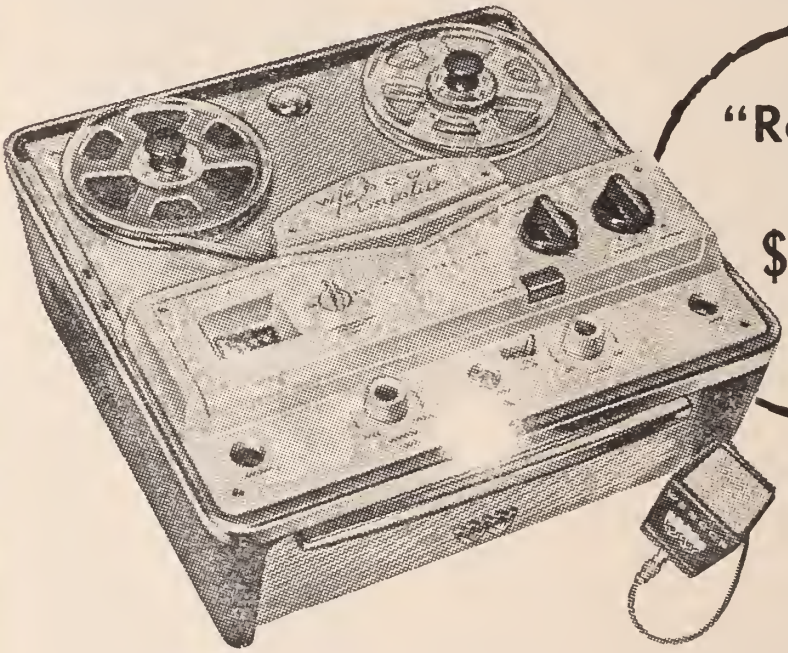
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case profile no. 2758*

for low back p

A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.



Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.

hat you
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THE FIRST TRUE TRANQUILAXANT

rancopal®

r dysmenorrhea
and premenstrual tension



case profile no. 3347*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

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- In musculoskeletal disorders, effective in 91% of patients.[1]
- In anxiety and tension states, effective in 88% of patients.[1]
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- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

Musculoskeletal:
Low back pain (lumbago, etc.)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
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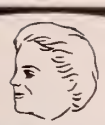
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1. Kolomeyer, N.: J. Amer. Geriat. Soc. 6:415, 1958. 2. Levy, S.: J.A.M.A. 153:1260, 1953.

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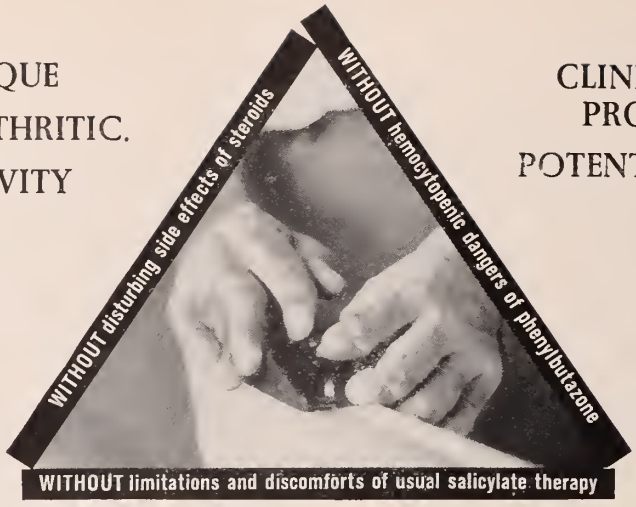
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CITED REFERENCES: 1. Clark, G. M.: Personal Communication, 1958. 2. Feldman, H. A.: Personal Communication, 1958. 3. Scully, F. J.: Treatment of Rheumatic Disorders with Choline Salicylate (to be submitted for publication). 4. Friedland, C. K.: Personal Communication, 1958. 5. Complete data available on request to the Medical Director.

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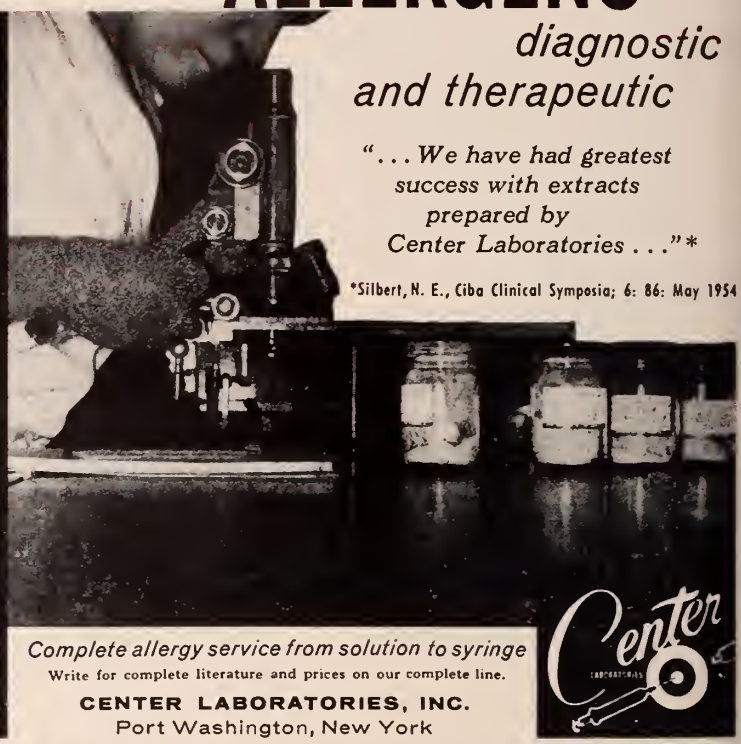
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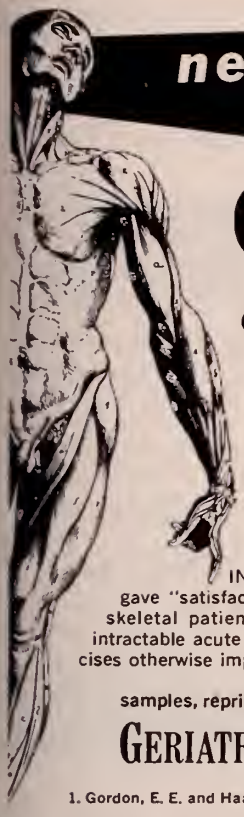
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1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

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CONTENTS—Pages 589 to 644

EDITORIALS— Page

The Crumbling Cordon of Confidentiality 589

Collapse of General Practice in Britain 590

The Risk of Telling the Truth 591

Blue Shield Accepts the Challenge 592

ORIGINAL ARTICLES—

Joint Changes in Malignant and Hematologic Diseases—Irving L. Sperling, M.D., Newark, N. J. 593

A New Oral Cholecystographic Medium—S. G. Bluestein, M. D., Paterson, N. J. 602

Surgical Treatment of Coronary Artery Disease—Nicholas A. Antonius, M.D., *et al.*, Newark, N. J. 605

Anomalous Return of the Pulmonary Veins—Albert B. Sarewitz, M.D. and R. Wendell Ward, M.D., South Orange, N. J. 611

Fracture of the Penis—Theodore L. Saxe, M.D., Jersey City, N. J. 614

Occupational Bronchial Asthma—Aaron Weiner, M.D., Fair Lawn, N. J. 616

ORIGINAL ARTICLES— Page

Focal Infection in Dermatology—Charles F. Post, M.D. and E. William Jewell, M.D., Ridgewood, N. J. 620

The Common Cold—I. J. Sobel, M.D., Passaic, N. J. 625

What's in the Air?—Robert B. Marin, M.D., Montclair, N. J. 629

HISTORICAL ARTICLE—

Hezekiah Stites—Regular Practitioner—Fred B. Rogers, M.D., Trenton, N. J. 630

ANNOUNCEMENTS 633

STATE ACTIVITIES—

Medical Reports to OASDI 636

M.D. License Plates 636

Supplementary List No. 1 to the 1959-60 Membership Directory 637

OBITUARIES 639

BOOK REVIEWS 640

NTA ABSTRACTS 643

Roster of Officers and Committee Chairmen, Advertising Page 3A

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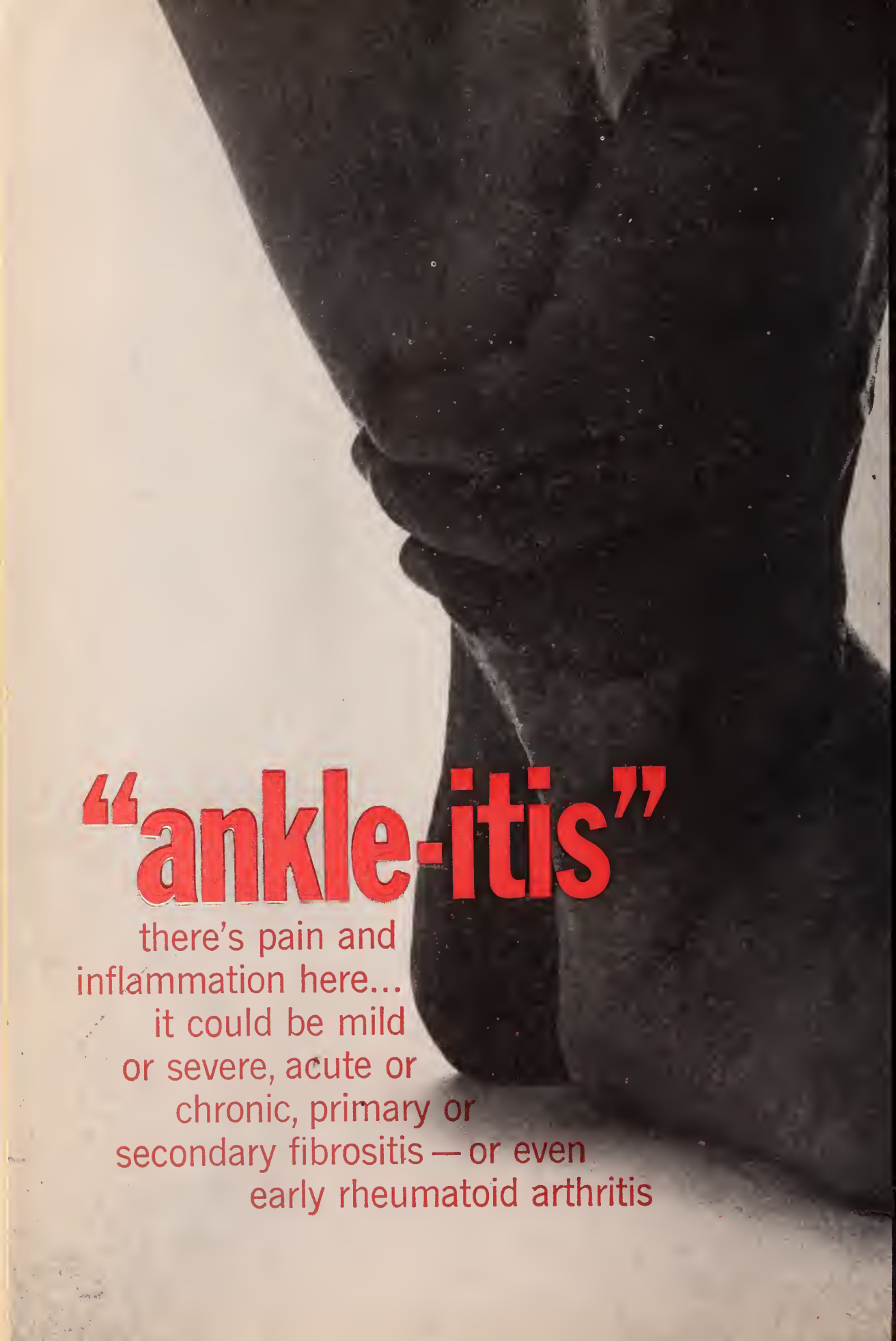
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References: **1.** Spies, T. D., et al.: J.A.M.A. 159:645, 1955. **2.** Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. **3.** Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. **4.** Guerra, F.: Fed. Proc. 12:326, 1953. **5.** Busse, E. A.: Clin. Med. 2:1105, 1955. **6.** Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

SG-J-61B

For the first time

CONVENIENCE and ECONOMY

for that all-important first dose of broad-spectrum antibiotic therapy

New

TERRAMYCIN®
brand of oxytetracycline

INTRAMUSCULAR SOLUTION



Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

...and for continued, compatible, coordinated therapy

COSA-TERRAMYCIN®
oxytetracycline with glucosamine

CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

Supply:
*Terramycin Intramuscular Solution** .
100 mg./2 cc. ampules
250 mg./2 cc. ampules

Cosa-Terramycin Capsules
125 mg. and 250 mg.

Cosa-Terramycin is also available as:
Cosa-Terramycin Oral Suspension — peach flavored, 125 mg./5 cc., 2 oz. bottle
Cosa-Terramycin Pediatric Drops — peach flavored, 5 mg./drop (100 mg./cc.), 10 cc. bottle with plastic calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

*Contains 2% Xylocaine® (lidocaine), trademark of Astra Pharmaceutical Products, Inc.

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PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
† 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

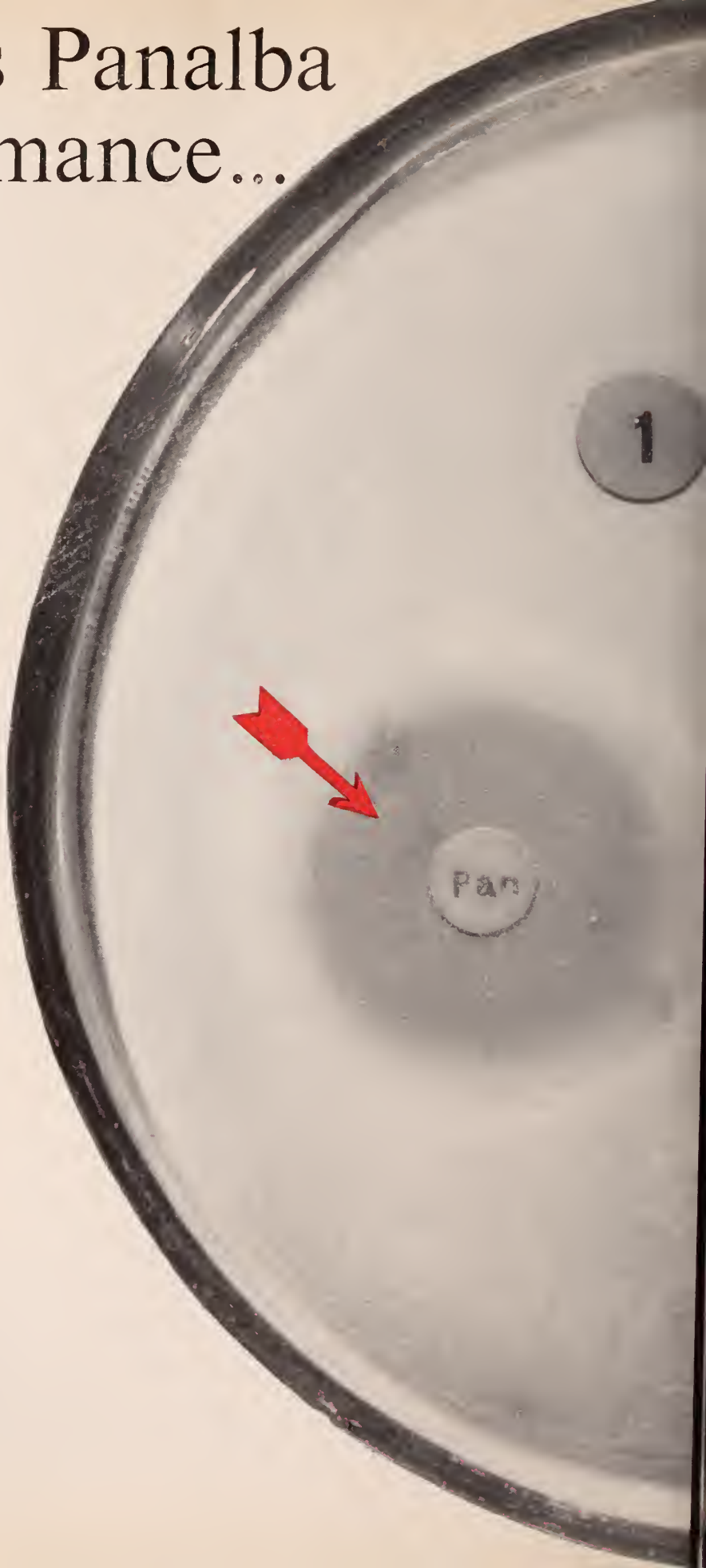
ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.

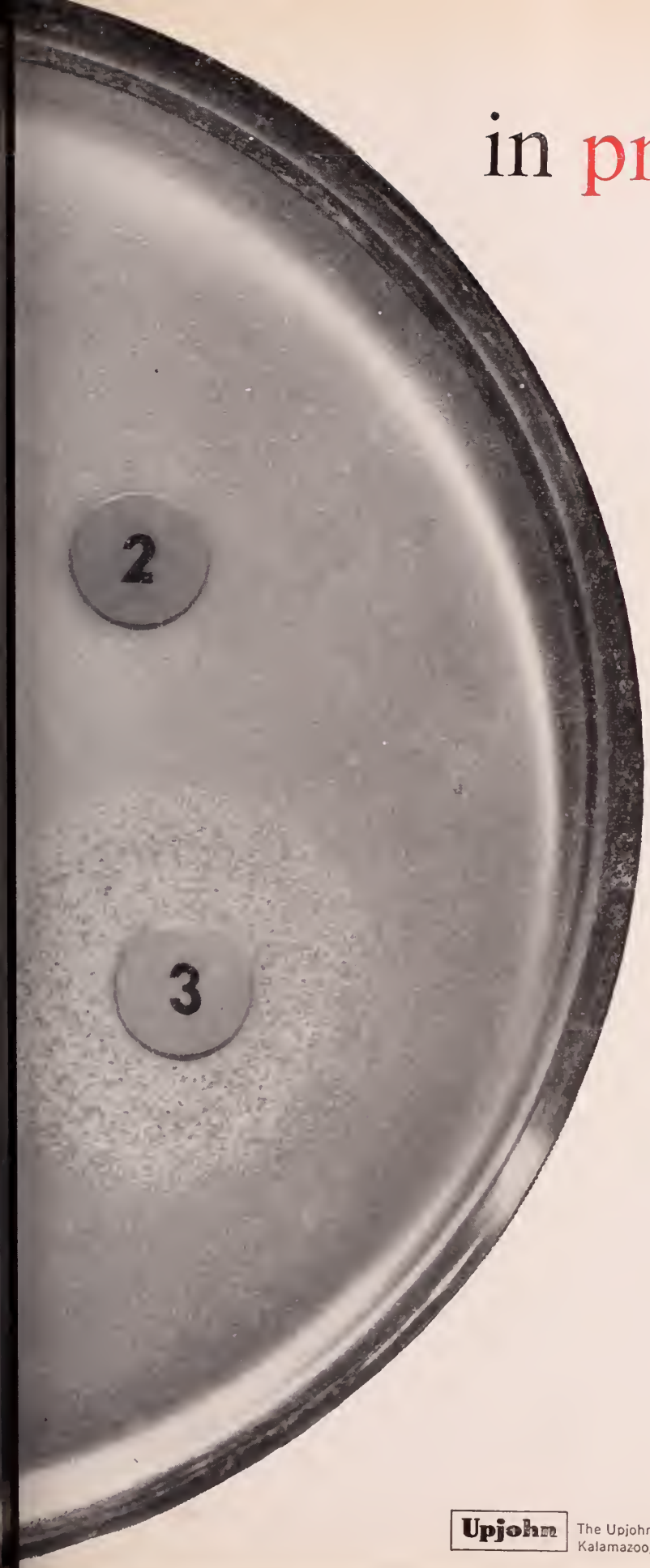
NATIONAL CASUALTY COMPANY
through
E. and W. BLANKSTEEN

NATIONWIDE MUTUAL INSURANCE CO.
through
E. and W. BLANKSTEEN AGENCY, Inc.

75 MONTGOMERY STREET **DELAWARE 3-4340** **JERSEY CITY 2, N. J.**

This is Panalba performance...





in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin* Phosphate plus Albamycin*)

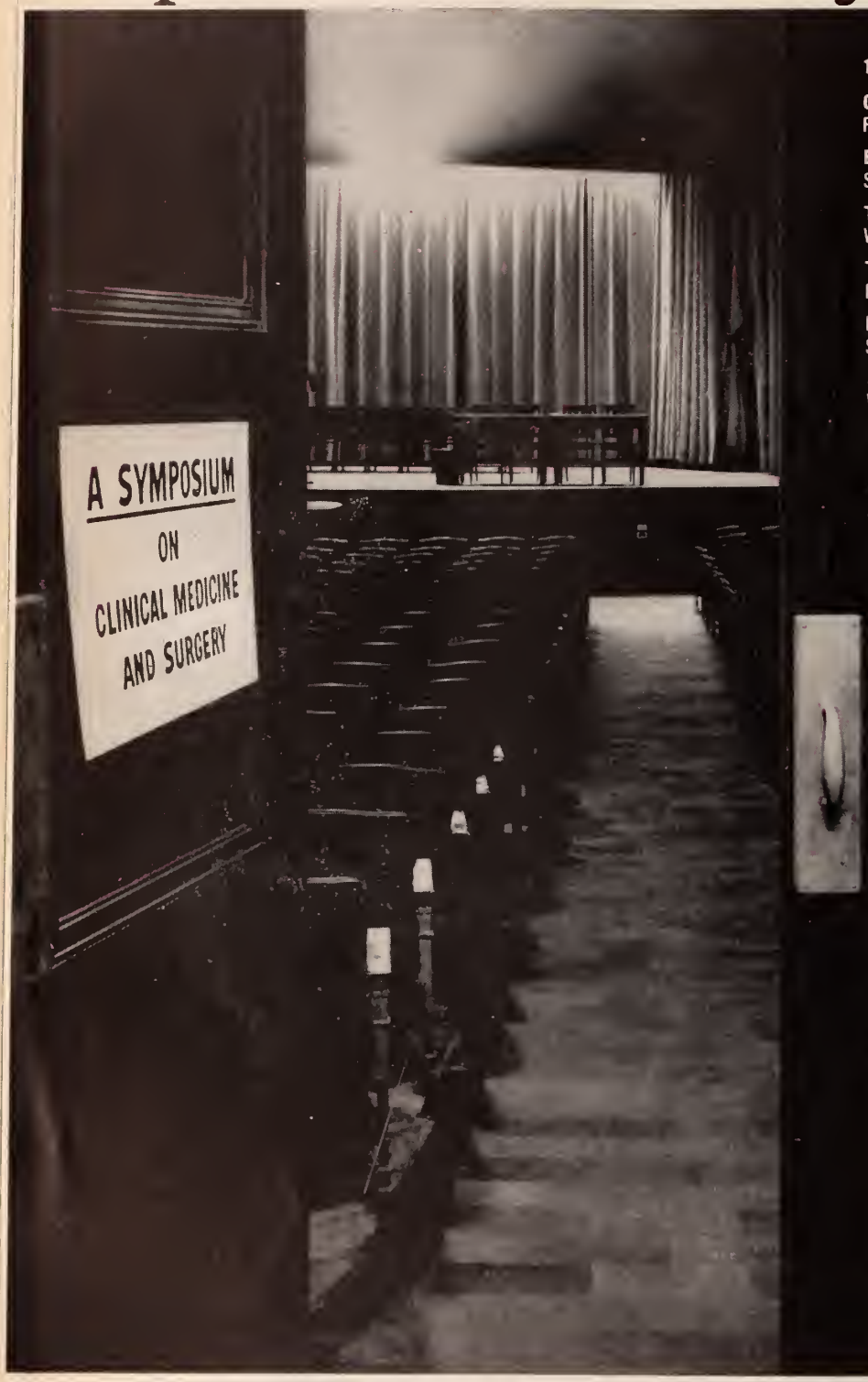
The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U.S. PAT. OFF.

Open To All Physicians



1959 Symposia

OKLAHOMA CITY, OKLAHOMA
Fri., Oct. 2, 1959, The Skirvin Hotel

BIRMINGHAM, ALABAMA
Sun., Oct. 11, 1959, The Dinkler-Tutwiler H

TACOMA, WASHINGTON
Wed., Oct. 14, 1959, The Hotel Winthrop

TRAVERSE CITY, MICHIGAN
Fri., Oct. 23, 1959, The Park Place Hotel

LUBBOCK, TEXAS
Sat., Oct. 31, 1959, The Lubbock Country

ST. CHARLES, ILLINOIS
Wed., Nov. 4, 1959, The St. Charles Coun

DALLAS, TEXAS
Fri., Nov. 6, 1959, The Hilton Hotel

WICHITA, KANSAS
Sat., Nov. 7, 1959, The Hotel Broadview

SCHENECTADY, NEW YORK
Thurs., Nov. 12, 1959, The Mohawk Golf

CORPUS CHRISTI, TEXAS
Fri., Nov. 13, 1959, The Robert Driscoll

RIVERSIDE, CALIFORNIA
Sun., Nov. 15, 1959, The Mission Inn

SANTA BARBARA, CALIFORNIA
Wed., Nov. 18, 1959, The Santa Barbara

MOLINE, ILLINOIS
Wed., Dec. 2, 1959, The LeClaire Hotel

1960 Symposia (incomplete schedu

DENVER, COLORADO
Sun., Jan. 10, 1960, The Cosmopolitan H

AUSTIN, TEXAS
Fri., Jan. 15, 1960, The Commodore Perr

POCATELLO, IDAHO
Sat., April 2, 1960, The Bannock Hotel

MOORHEAD, MINNESOTA
Sat., April 9, 1960, The Frederick Martin

SALT LAKE CITY, UTAH
Fri., April 22, 1960, Hotel Utah

ST. LOUIS, MISSOURI
Sun., May 1, 1960, Chase-Park Plaza

SANTA ROSA, CALIFORNIA
Fri., Sept. 16, 1960, The Flamingo Hot

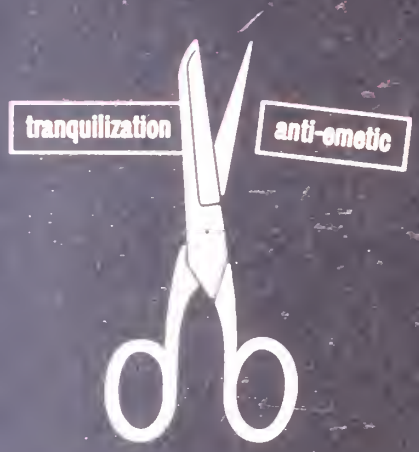
GREAT FALLS, MONTANA
Sat., Oct. 22, 1960, The Rainbow Hotel

CHARLESTON, WEST VIRGINIA
Sun., Oct. 30, 1960, The Daniel Boone

In cooperation with medical organizations throughout the United States, Lederle continues to offe post-graduate medical education through its Symposium program. Upon completion of the schedul the number of Symposia presented will exceed 200 since the first meeting, sponsored by the K (Tenn.) Academy of Medicine eight years ago. Each meeting presents prominent authorities dis important advances in clinical medicine and surgery. Activities are also planned for physicians

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Peorl River, New York

now potent tranquilizer therapy is safer than ever



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

- **jaundice**
- **Parkinsonism**
- **blood dyscrasia**

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has bee almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, derma even when given in quantities far in excess of the usual dosage.

"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responde reduction in dosage. Other side effects did not occu It is singularly free from the side effects ordinarily with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common administration of the phenothiazines, was present du the period of Thioridazine administration: Parkin ism or Parkinson-like symptoms, photosensitivity, o static hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaun and photosensitivity have not been observed in pat treated with Thioridazine [Mellaril]. Extrapyra side effects produced by other phenothiazines disappeared promptly with no deterioration in th havioral response when these patients have been sh to Thioridazine."[5]

NO JAUNDICE

"No allergic reactions were observed such as skin tions, jaundice or agranulocytosis. Central ner system toxicity, as manifested by extrapyramidal ef seizures, and excitement did not occur despite th of high doses (up to 2000 mg.) of the drug."[6]

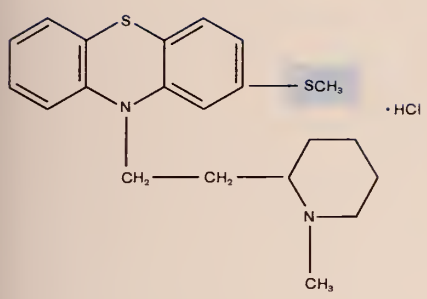
Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

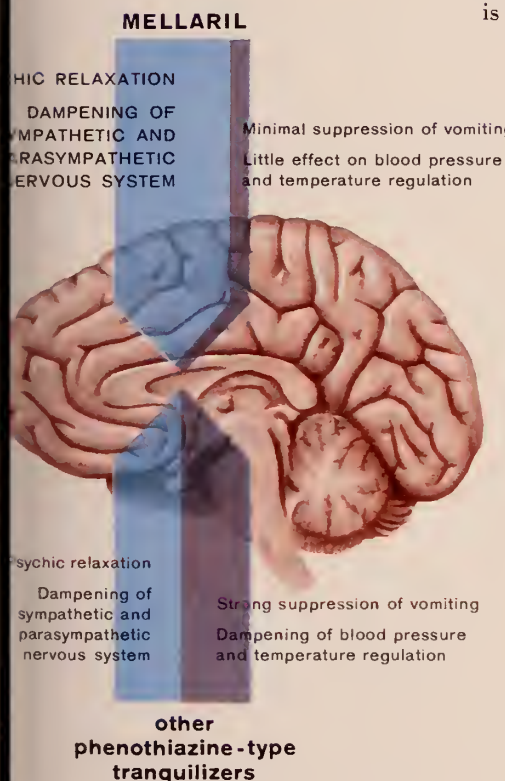
tranquilization anti-emetic

new advance in tranquilization:
reater specificity of tranquilizing action plus fewer side effects



Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical (S-CH_3) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.





2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

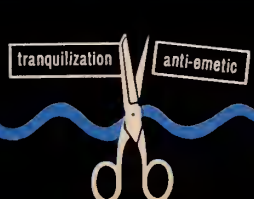
3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

Mellaril®
THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels



a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to mg. three times a day may be administered.

Dosage must be individualized according to the co tion and degree of response. In all cases, the sma effective dosage should be determined for each pat

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANG
ADULTS		
Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hem depression, jaundice or orthostatic hypotension. other phenothiazines, Mellaril is contraindic severely depressed or comatose states from any ca

SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lectur Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medi ation, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit. Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association: Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb

- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

SA





running noses



and open stuffed noses orally

Triaminic®

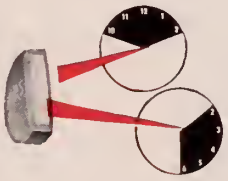
the leading oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

safer and more effective than topical medication[1,2,3]

- systemic transport to all respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each TRIAMINIC Tablet provides:
Phenylpropanolamine HCl .....50 mg.
Pheniramine maleate .....25 mg.
Pyrilamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to ¼ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

CASE HISTORY OF AN ARTHRITIC

Age: 55 Sex: Male Race: White

Diagnosis: Rheumatoid arthritis.

Previous Therapy:
40 mg. triamcinalone per day.

Complicating States:
Duodenal ulcer, steroid intoxication.

Current Therapy: ARTHROPAN Liquid.

Results: The patient improved on ARTHROPAN and "...is now on Choline Salicylate [ARTHROPAN] alone and has returned to work."[1]



SUPPLIED: 8 and 16 oz. bottles.
Each ml. of ARTHROPAN Liquid contains 174 mg. of Choline Salicylate.
Each teaspoonful (5 ml.) contains 870 mg. of Choline Salicylate.

1. Clark, G.M.: Personal Communication, 1958.

ARTHROPAN T.M.
LIQUID

BRAND OF CHOLINE SALICYLATE

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DEDICATED TO PHYSICIAN AND PATIENT SINCE 1892
NEW YORK 14, N.Y. | TORONTO 1, ONTARIO

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Announcing

'ACTIFED'®

Decongestant / Antihistamine

THE POTENTIATED DECONGESTANT



provides symptomatic relief of nasal congestion and rhinorrhea of allergic or infectious origin Many patients whose symptoms are inadequately controlled by decongestants or antihistamines alone respond promptly and favorably to 'ACTIFED'.

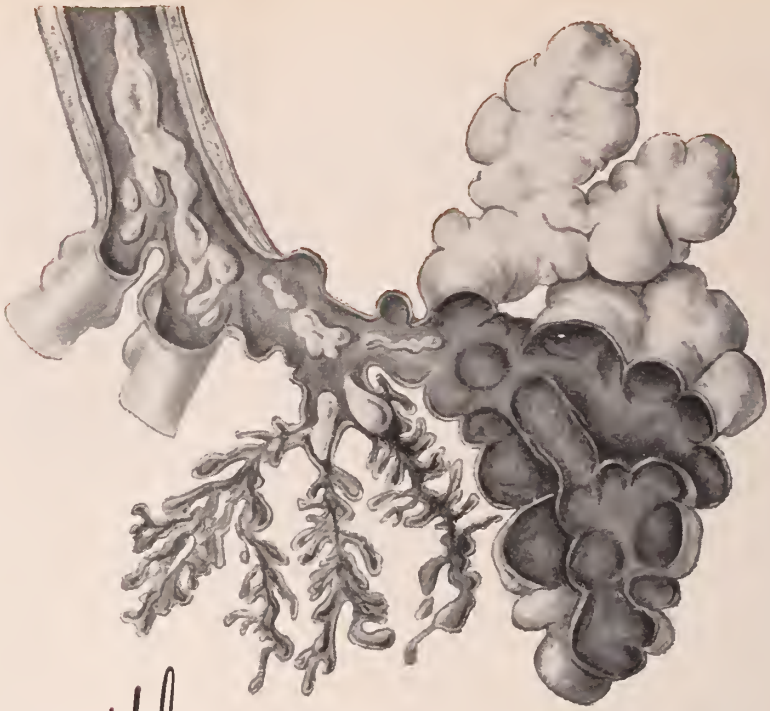
'ACTIFED' contains:	in each Tablet	in each tsp. Syrup
'Actidil'® brand Triprolidine Hydrochloride	2.5 mg.	1.25 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	60 mg.	30 mg.

safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York



Clear the air

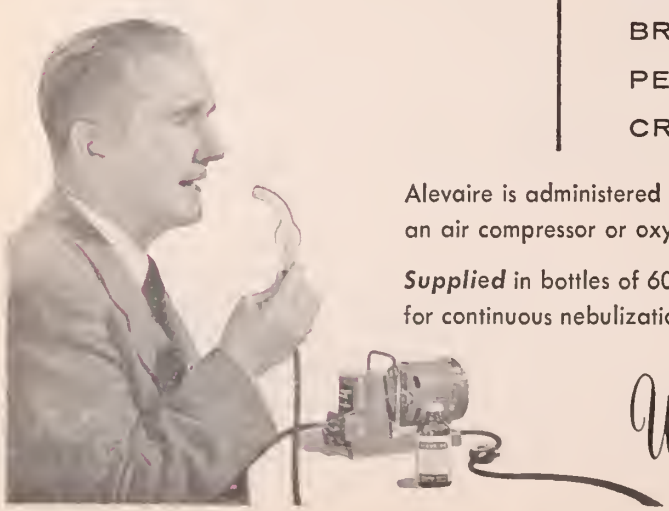
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inhalation therapy

WETS, THINS, LOOSENS PULMONARY SECRETIONS

Very useful in...

... BRONCHITIS
BRONCHIAL ASTHMA
BRONCHIECTASIS
PERTUSSIS
CROUP



Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

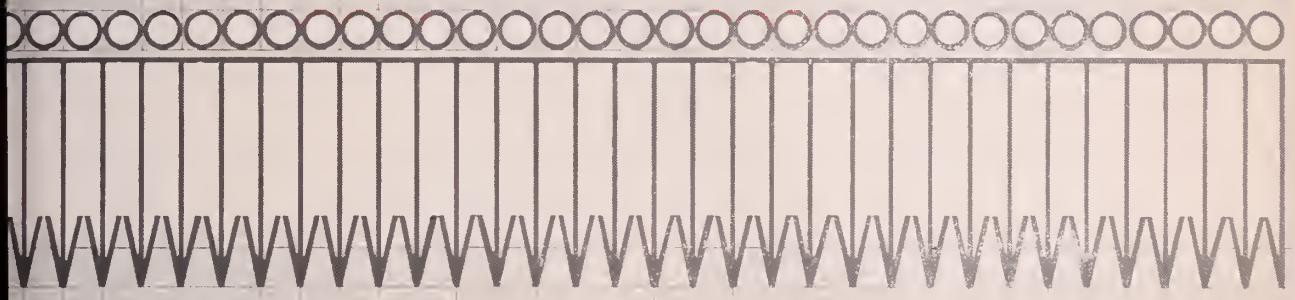
Winthrop LABORATORIES
NEW YORK 18, N. Y.

Alevaire, trademark reg. U.S. Pat. Off.

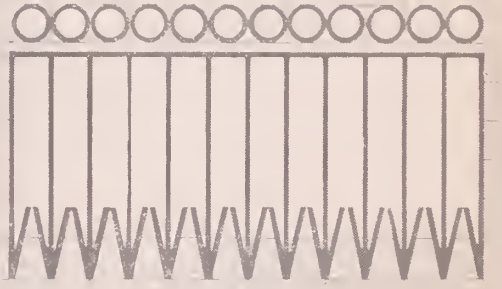
Decadron®

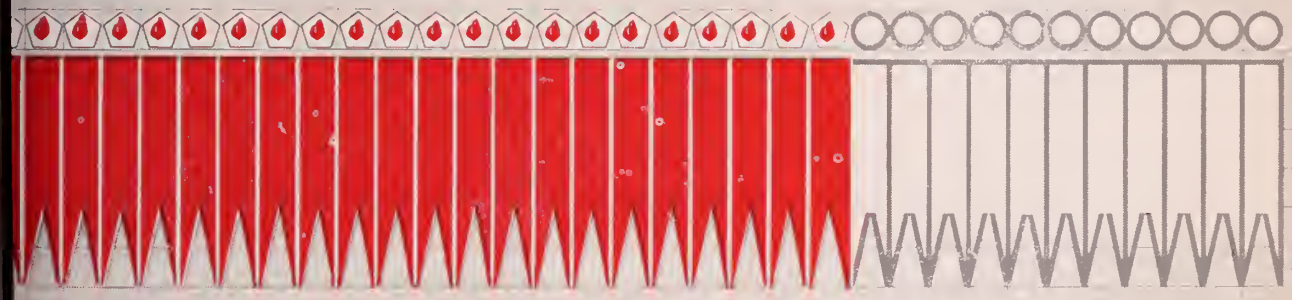
DEXAMETHASONE

treats more patients more effectively...



Of 45 arthritic patients who were refractory to other corticosteroids*





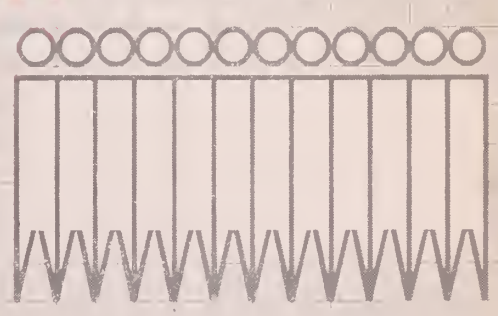
22 were successfully treated with **Decadron**[1,2]

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

DECADRON is a trademark of Merck & Co., Inc.

Additional information on DECADRON is available to physicians on request.



MSD Merck Sharp & Dohme

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Where a poly-unsaturated oil is called for in the diet, **Wesson** satisfies the most exacting requirements

(and the most exacting palates!)



More acceptable to patients. Wesson contributes greatly to the palatability of food and, thus, can be important in encouraging patients to maintain prescribed restricted diets. By the criteria of odor, flavor (blandness) and lightness of color, housewives prefer Wesson.*

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson, and no significant variations are permitted in the 22 exacting specifications required before bottling.

Economy. Wesson is consistently priced lower than next largest seller, a not unimportant considerati where poly-unsaturated oil is called for.

Wesson's Active Ingredients:	
Linoleic ocid glycerides	50% to 55
Phytosterol (predominantly beta sitosterol)	0.4% to 0.7
Totol tocopherols	0.09% to 0.12
Never hydrogenoted—completely salt free	

* Reconfirmed by recent tests against the next leading brand with l identifications removed, among a national probability sample.

Synonyms for Pain Relief...

ABLOID' EMPIRIN' COMPOUND®

Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½

ABLOID' EMPIRIN' COMPOUND® WITH CODEINE PHOSPHATE*

NO. 1
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . gr. ⅛

NO. 2
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate gr. ¼

NO. 3
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . gr. ½

NO. 4
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . . gr. 1

*Subject to Federal Narcotic Regulations

...providing the desired gradation of potencies for relief of varying intensities of pain

IN

simple headache
rheumatic conditions
arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
minor trauma
tension headache
premenstrual tension
minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis / bursitis

relief of pain
of all degrees of
severity up to
that which
requires morphine

AND IN

fevers
dry,
unproductive coughs



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Your experience and trust throughout the
years have established the wide use of th
'Empirin' family in medical practice—
dependable analgesics for the effective re
of pain, fever, and cough—with safety.



BURROUGHS WELLCOME & CO. (U.S.A.) INC.
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make them measure up



Incremin® with iron Syrup

Lysine-Vitamins Lederle

help restore the normal blood picture—iron as ferric pyrophosphate to restore or maintain normal hemoglobin.

boost appetite and energy—vitamins . . . B_1, B_6 and B_{12}.

upgrade low-grade protein—cereals and other low protein favorites of children, upgraded by l-Lysine, work with meat and other top protein to build stronger bodies.

tastes good! Each daily cherry-flavored teaspoonful dose (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	0.75%

Bottles of 4 and 16 fl. oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

NO SALT ..*but seasoned*



A meal of even the most colorful and the most meticulously prepared food can be dreary eating without salt. Neocurtasal, for the patient on a low-sodium diet, brings back flavor to foods—makes eating a pleasure once more.

Neocurtasal®

An excellent salt replacement
for
"Salt-Free" (Low Sodium) Diets

Contains potassium chloride, potassium glutamate, glutamic acid, calcium silicate, potassium iodide (0.01%).

2 oz. shakers and
8 oz. bottles

Sold Only Through Drugstores

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Assures patient's cooperation

MICRONITE FILTER:

key to Kent's popularity

During the past year, Kent sales increased by 20-billion cigarettes—the greatest gain in popularity ever recorded by any filter cigarette in any year.

Undoubtedly much of the credit for this important rise in sales must go to Kent's exclusive "MICRONITE" Filter. This extraordinary new filter was constructed to take into account new principles of filtration which were dictated by the basic discoveries of a major research foundation, working under Lorillard sponsorship.

The foundation determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Additional research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the exclusive Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. In this maze-like network of super-fine filters the smoke particle has much less chance to slip through the filter.

Thus, Lorillard research created a filter which reduced tars and nicotine in the "inhaled" smoke to the lowest level among the largest selling brands. As smokers learned about the "MICRONITE" Filter, they changed to Kent. During the past year, for instance, more smokers changed to Kent than to any other cigarette in America.



If you would like for your own use the booklet, "The Story of Kent," write to:

P. Lorillard Company
Research Department
200 East 42nd Street
New York 17, N. Y.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

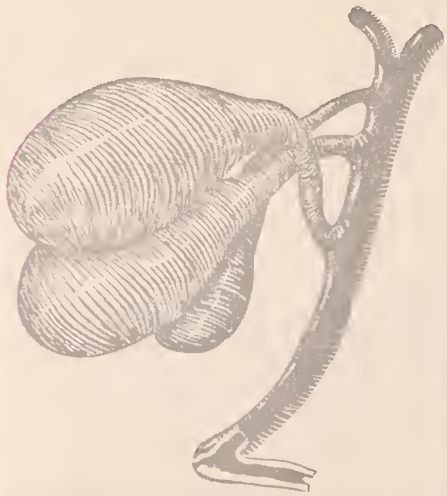
AN AMES CLINIQUICK™

CLINICAL BRIEFS FOR MODERN PRACTICE

HOW PREVALENT ARE MULTIPLE GALLBLADDER ANOMALIES?

One hundred and twenty-two cases of *vesica fellea divisa* (bilobed gallbladder) and *vesica fellea duplex* (double gallbladder with 2 cystic ducts) are reported in the literature. A unique case of *vesica fellea triplex* has recently been described.

Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



in medical management and postoperative care of biliary disorders...

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DECHOLIN®

(dehydrocholic acid, AMES)

"...dehydrocholic acid...does considerably increase the volume output of a bile of relatively high water content and low viscosity. This drug is therefore a good 'flusher,' and is effectively used in treating both the chronic unoperated patient and the patient who has a T-tube drainage of an infected common bile duct."[1]

free-flowing bile
plus reliable spasmolysis

DECHOLIN® WITH BELLADONNA

"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."[2]

(1) Beckman, H.: Drugs: Their Nature, Action and Use. Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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Fiber of skeletal muscle in spasm

Fiber of skeletal muscle relaxed *(photomicrographs)*



CLINICALLY PROVEN –prolonged relaxation of acute skeletal muscle spasm

Robins

Robaxin®

thocarbamol Robins U.S. Pat. No. 2770649

TABLETS

mmary of six published clinical studies:

OBAXIN BENEFICIAL IN 92.4% OF KELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
rpenter[1]	33	26	6	1	—
		"pronounced"			
rsyth[2]	58	37	20	—	1
		"good"			
wis[3]	38	25	6	—	7
Doherty & ields[4]	17	"excellent" 14	2	1	0
		"significant"			
rk[5]	30	27	—	2	1
		"gratifying"			
umb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

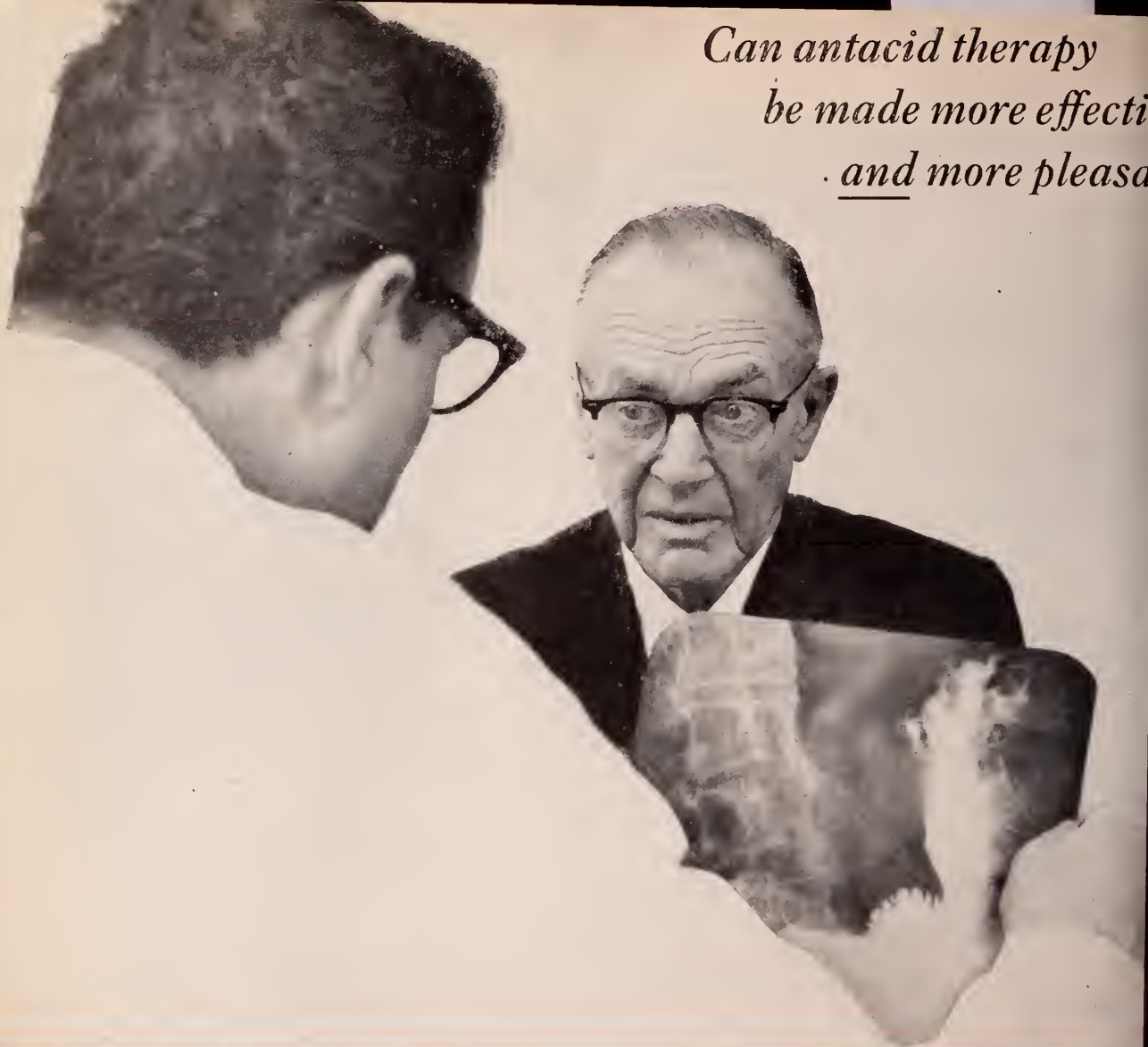
- Highly potent—and long acting.[1,2,3]
- Relatively free of adverse side effects.[1,2,3,5,6]
- In ordinary dosage, does not reduce muscle strength or reflex activity.[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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Ethical Pharmaceuticals of Merit

Can antacid therapy
be made more effecti
and more pleasa



THE MOST SIGNIFICANT IMPROVEMENT IN ANTACID THERAPY SINCE THE INTRODUCTI OF ALUMINUM HYDROXIDE IN 1929

NEW

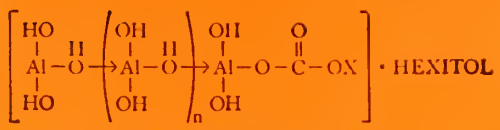
Creamalin®

ANT
TAB

Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, sho mer dried aluminum hydroxide gel, (stabilized with hexitol), with 75 mg. magnesium hyd

1. *Neutralizes acid faster (quicker relief)*
2. *Neutralizes more acid (greater relief)*
3. *Neutralizes acid longer (more lasting relief)*
4. *No constipation · No acid rebound*

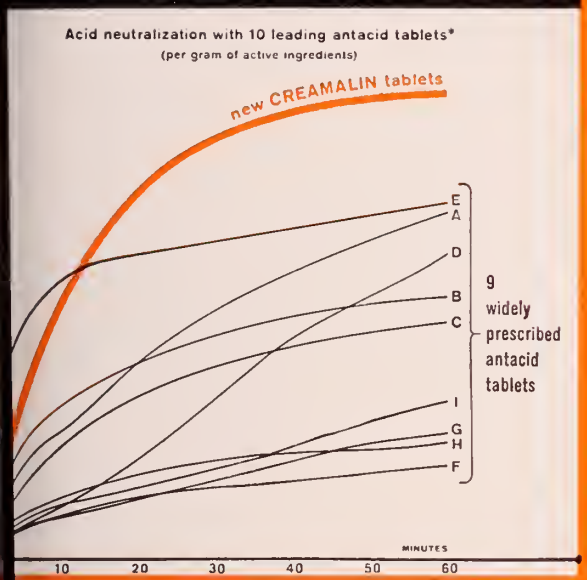
new high in effectiveness
d palatability



n is at least 1 and averages less than 6. X is a cation.

:AMALIN NEUTRALIZES *MORE* ACID *FASTER*

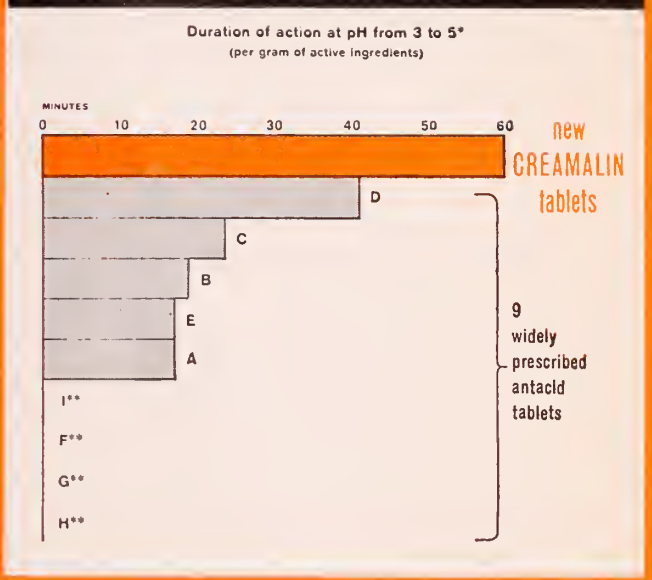
Quicker Relief • Greater Relief



re powdered and suspended in distilled water in a constant temperature (37°C) equipped with mechanical stirrer and pH electrode. Hydrochloric added as needed to maintain pH at 3.5. Volume of acid required was at frequent intervals for one hour.

CREAMALIN NEUTRALIZES *MORE* ACID *LONGER*

More Lasting Relief



*Hinkel, E. T., Jr., Fisher, and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.

Do antacids have to taste like chalk?





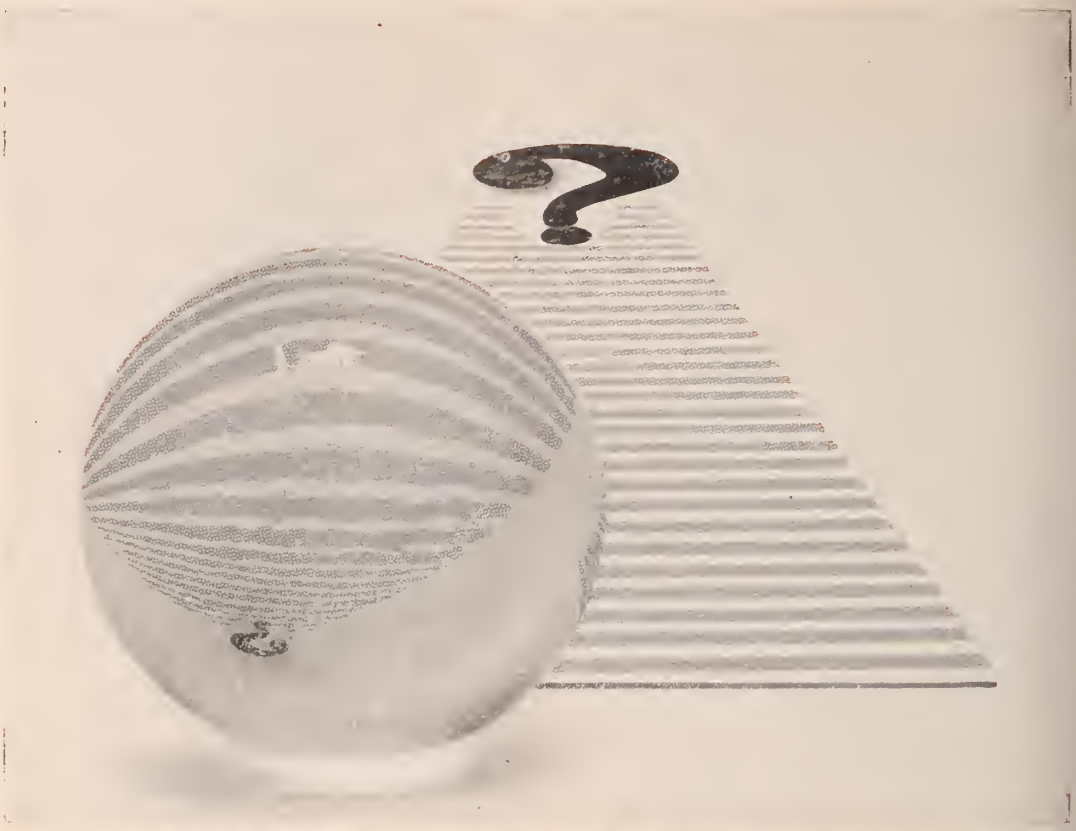
No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

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what lurks beyond the broad spectrum?

"Broad spectrum" has evolved into an especially apt term to describe a growing number of "specialized" antibiotics. These provide the best means of destroying pathogenic bacteria which range all the way from large protozoa through gram-negative and gram-positive bacteria to certain viruses at the far end of the spectrum.

But beyond the spectrum lurk pathogenic fungi. Aggressive infections often require intensive broad spectrum antibiotic attack. It becomes more apparent every day that fungal superinfections may occur during or following a course of such therapy.[1,2] Long term debilitating disease, diabetes, pregnancy, corticosteroid therapy, and other causes may predispose to such fungal infections[1,3,4] as iatrogenic moniliasis. These facts complicate the administration of antibiotics.

Mysteclin-V controls both – infection and superinfection. Mysteclin-V makes a telling assault on bacterial infections and, in addition, prevents the potentially dangerous monilial overgrowth.[2,5-8] Mysteclin-V is a combination of the phosphate complex of tetracycline – for reliable control of most infections encountered in daily practice – and Mycostatin, the first safe antifungal antibiotic.

Case history after case history marked "recovered" provides clinical evidence of the special merit of this advance in specially designed antibiotics. When you prescribe Mysteclin-V, you provide "broad therapy" with extra protection that extends beyond the spectrum of ordinary antibiotics.

'MYSTECLIN'®, 'SUMYCIN'®, AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

Supplied:	Tetracycline Phosphate Complex equiv. Tetracycline HCl (mg.)	Mycostatin units
Mysteclin-V Capsules (per capsule)	250	250,000
Mysteclin-V Half-Strength Capsules (per capsule)	125	125,000
Mysteclin-V Suspension (per 5 cc.)	125	125,000
Mysteclin-V Pediatric Drops (per cc. – 20 drops)	100	100,000

References: 1. Dowling, H. F.: Postgrad. Med. 23:594 (June) 1958 2. Gimble, A. I.; Shea, J. G., and Katz, S.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1956, p. 676. 3. Long, P. H., in Kneeland, Y., Jr., and Wortis, S. B.: Bull. New York Acad. Med. 33:552 (Aug.) 1957. 4. Rein, C. R.; Lewis, L. A., and Dick, L. A.: Antibiotic Med. & Clin. Ther. 4:771 (Dec.) 1957. 5. Stone, M. L., and Mershelmer, W. L.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1956, p. 862. 6. Campbell, E. A.; Prigot, A., and Dorsey, O. M.: Antibiotic Med. & Clin. Ther. 4:817 (Dec.) 1957. 7. Chamberlain, C.; Burros, H. M., and Borromeo, V.: Antibiotic Med. & Clin. Ther. 5:521 (Aug.) 1958. 8. From, P., and Alli, J. H.: Antibiotic Med. & Clin. Ther. 5:639 (Nov.) 1958.

Mysteclin - V

SQUIBB TETRACYCLINE PHOSPHATE COMPLEX (SUMYCIN) AND NYSTATIN (MYCOSTATIN)

SQUIBB

Squibb Quality – the Priceless Ingredient


Outstanding
relief from
torticollis and
anxiety and
tension states
with
Trancopal®
THE FIRST TRUE "TRANQUILAXANT"

THE FIRST TRUE "TRANQUILAXANT"

Trancopal

potent MUSCLE RELAXANT
effective TRANQUILIZER

Indications:

Musculoskeletal[1]	Psychogenic[1]
Neck pain (torticollis, etc.)	Anxiety and tension states
Low back pain (lumbago, etc.)	Dysmenorrhea
Bursitis	Premenstrual tension
Rheumatoid arthritis	Asthma
Osteoarthritis	Angina pectoris
Disc syndrome	Alcoholism
Fibrositis	
Ankle sprain, tennis elbow, etc.	
Myositis	
Postoperative muscle spasm	

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours. The higher dosage is recommended for the treatment of patients in the acute stages of painful musculospastic conditions, and anxiety and tension states. Children (5 to 12 yrs.), 50 mg. three or four times daily.

Supply:

Trancopal Caplets®
100 mg. (peach colored, scored), bottles of 100.

New strength ▶ Trancopal Caplets
200 mg. (green colored, scored), bottles of 100.

"Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."[3]

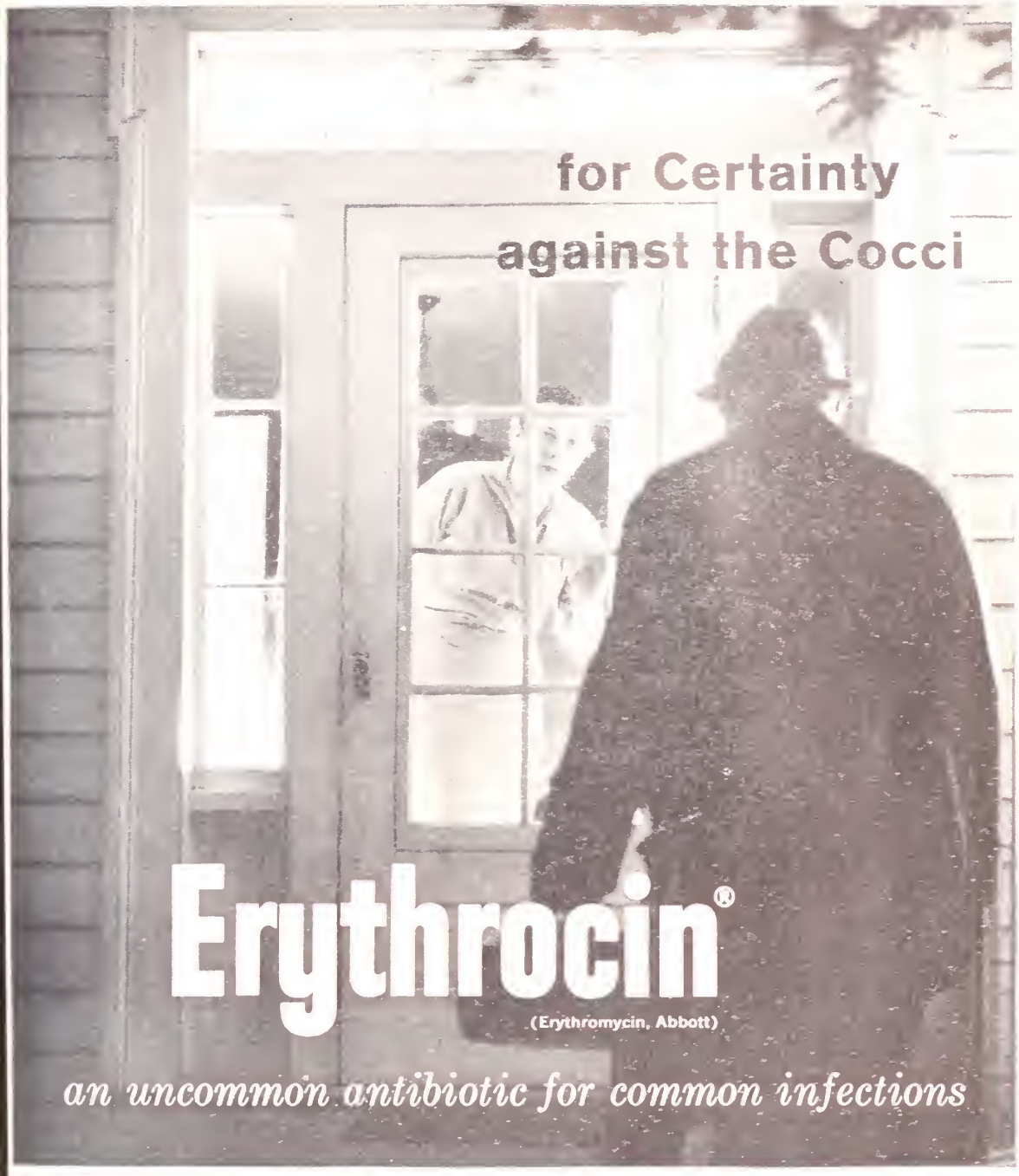
". . . Trancopal is a most valuable drug for relieving tension, apprehension and various psychogenic states."[4]

1. Collective Study, Department of Medical Research, Winthrop Laboratories.
2. Lichtman, A. L. (N.Y. Polyclinic M. Sch. & Hosp.): Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.
3. Mullin, W. G., and Epifano, Leonard (Long Island College Hosp.): Am. Pract. & Digest Treat. To be published.
4. Ganz, S. E. (New York, N. Y.): J. Indiana M. A. 52:1134, July, 1959.



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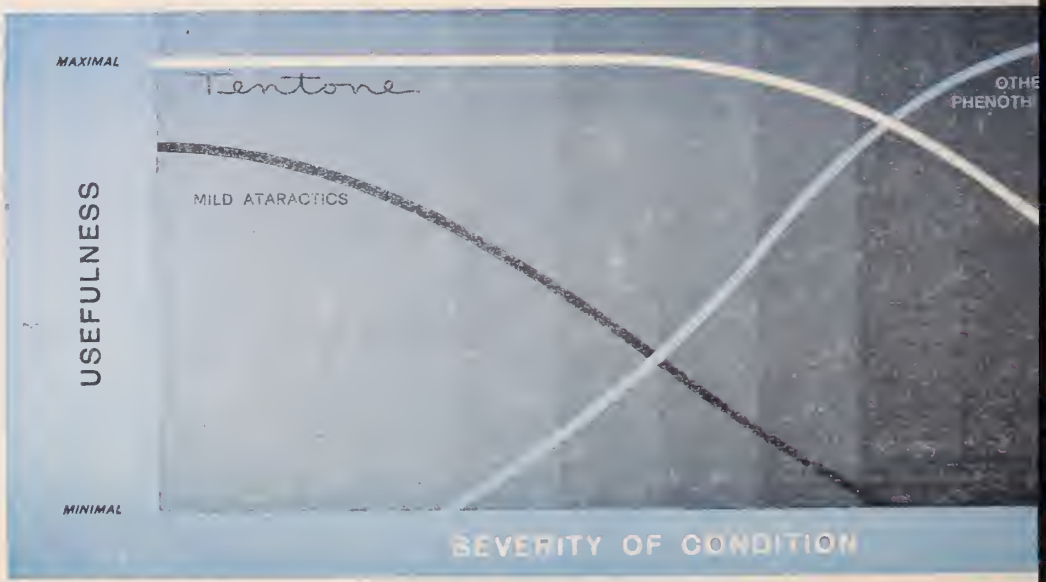
Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off. Printed in U.S.A. 9-59 (1400M)



Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and
for intravenous and intramuscular use.

new...highly effective tranquili

Comparison of TENTONE usefulness



for extended office practice use

Tentone

xypromazine Maleate

LEDERLE

PHENOTHIAZINE COMPOUND FOR THE LOWER AND MIDDLE RANGE OF DISORDERS

– Positive, rapid calming effect in mild and moderate cases. – Striking freedom from organic toxicity, intolerance, or sen- ty reaction—particularly at low dosage. ◆ Greater freedom induced depression or drug habituation. ◆ May be use- s with other tranquilizers, to potentiate action of analgesics, ives, narcotics. ◆ Facilitates management of surgical, tric, and other hospitalized patients. ◆ Indicated when than a mild sedative effect is desired...and less than psy- s is involved. ◆ Dosage range: *In mild to moderate cases:* 30 to 100 mg. daily. *In moderate to severe cases:* from 75 to ng. daily.



DERLE LABORATORIES, a Division of **AMERICAN CYANAMID COMPANY,** Pearl River, New York

Lederle

CHOICE THERAPY FOR THE "OLDER" PATIENT WITH MILD TO MODERATE HYPERTENSION



Rx Veratrite®

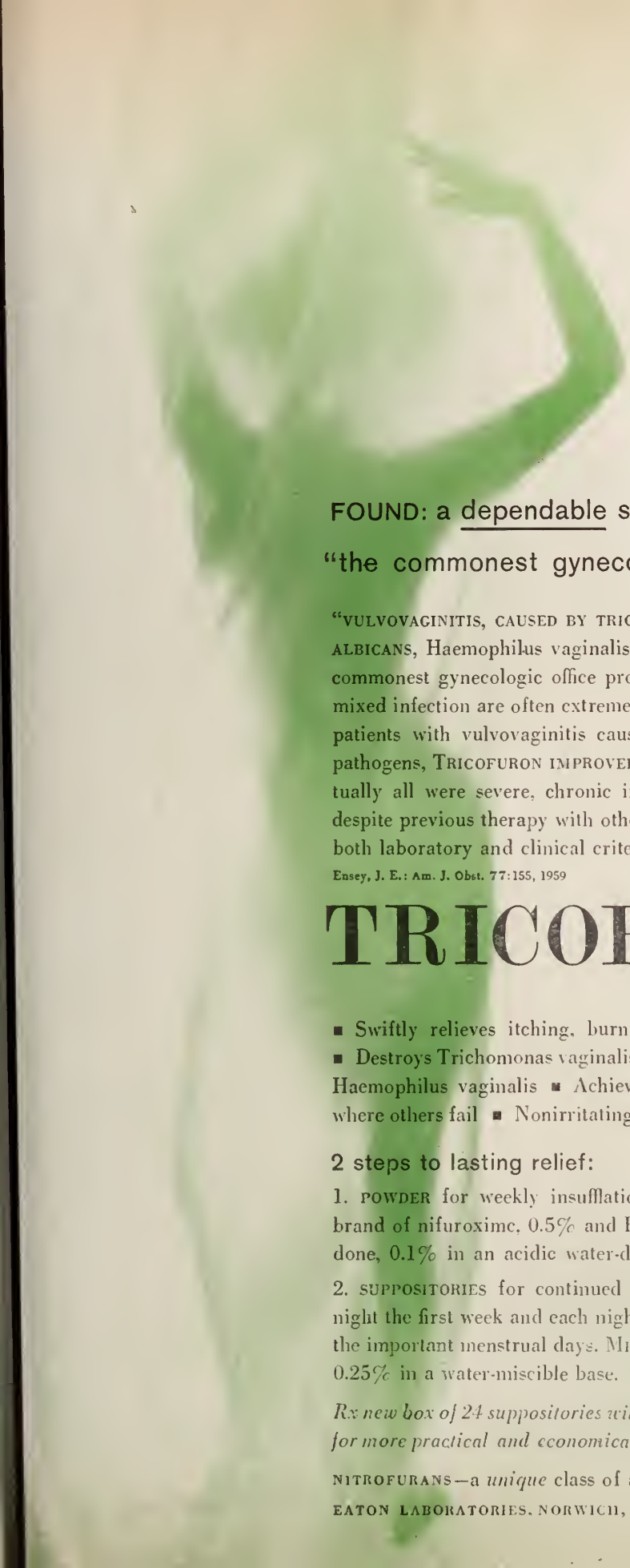
More than 13,000,000 prescriptions attest that Veratrite continues to be the antihypertensive of choice for the older hypertensive patient. Veratrite can be prescribed safely and routinely for those who usually cannot tolerate more potent drugs.

Veratrite now contains cryptenamine which acts centrally to produce a gradual fall in blood pressure, yet improves circulation to vital organs, relieves dizziness and headache, and imparts a distinct sense of well-being. Furthermore, Veratrite achieves its effects with unusual safety and without annoying side effects.

Each Veratrite tabule contains: Cryptenamine (tannates), 40 C.S.R.* Units; Sodium nitrite, 1 gr.; Phenobarbital, ¼ gr. Dosage: 1–2 tabules t.i.d., preferably 2 hours after meals.

*Carotid Sinus Reflex

Neisler IRWIN, NEISLER & CO. • DECATUR, ILLINOIS



FOUND: a dependable solution to

"the commonest gynecologic office problem"

"VULVOVAGINITIS, CAUSED BY TRICHOMONAS VAGINALIS, CANDIDA ALBICANS, Haemophilus vaginalis, or other bacteria, is still the commonest gynecologic office problem . . . cases of chronic or mixed infection are often extremely difficult to cure." Among 75 patients with vulvovaginitis caused by one or more of these pathogens, TRICOFURON IMPROVED cleared symptoms in 70; virtually all were severe, chronic infections which had persisted despite previous therapy with other agents. "Permanent cure by both laboratory and clinical criteria was achieved in 56. . . . "

Ensey, J. E.: Am. J. Obst. 77:155, 1959

TRICOFURON®

Improved

■ Swiftly relieves itching, burning, malodor and leukorrhea ■ Destroys Trichomonas vaginalis, Candida (Monilia) albicans, Haemophilus vaginalis ■ Achieves clinical and cultural cures where others fail ■ Nonirritating and esthetically pleasing

2 steps to lasting relief:

1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. SUPPOSITORIES for continued home use each morning and night the first week and each night thereafter—especially during the important menstrual days. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy.

NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES, NORWICH, NEW YORK

avoid the risk of insoluble irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4,5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2,4,5] This is reported to be particularly true in patients with peptic ulcer.

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



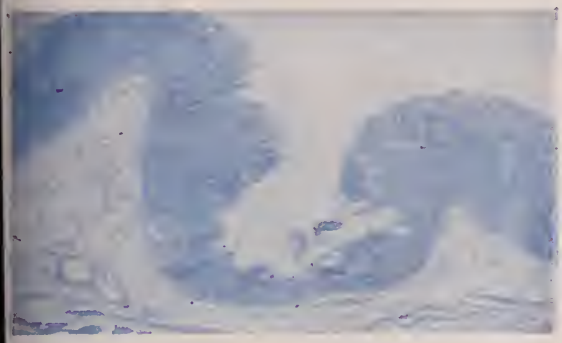
Regular aspirin crystals 24 hours after being mixed into water.



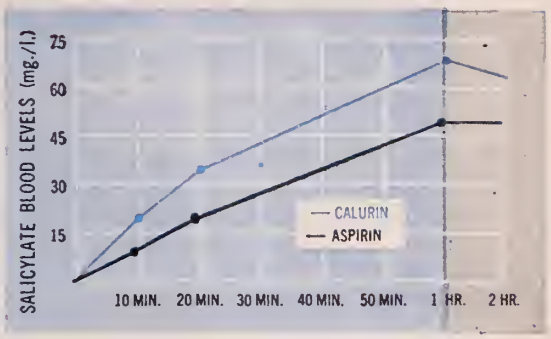
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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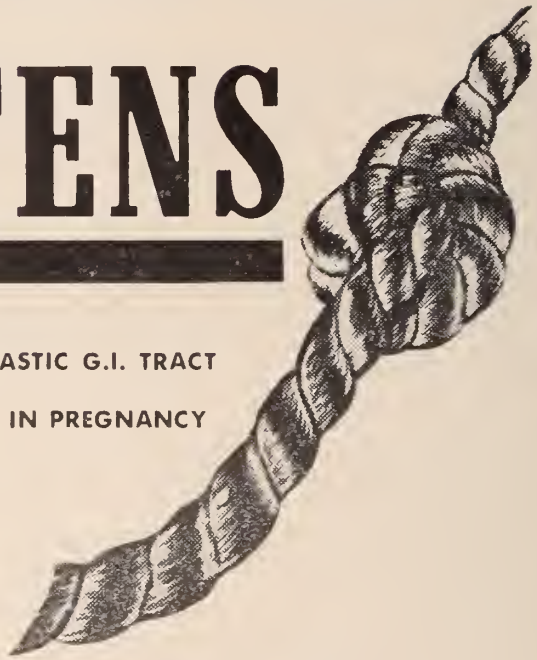
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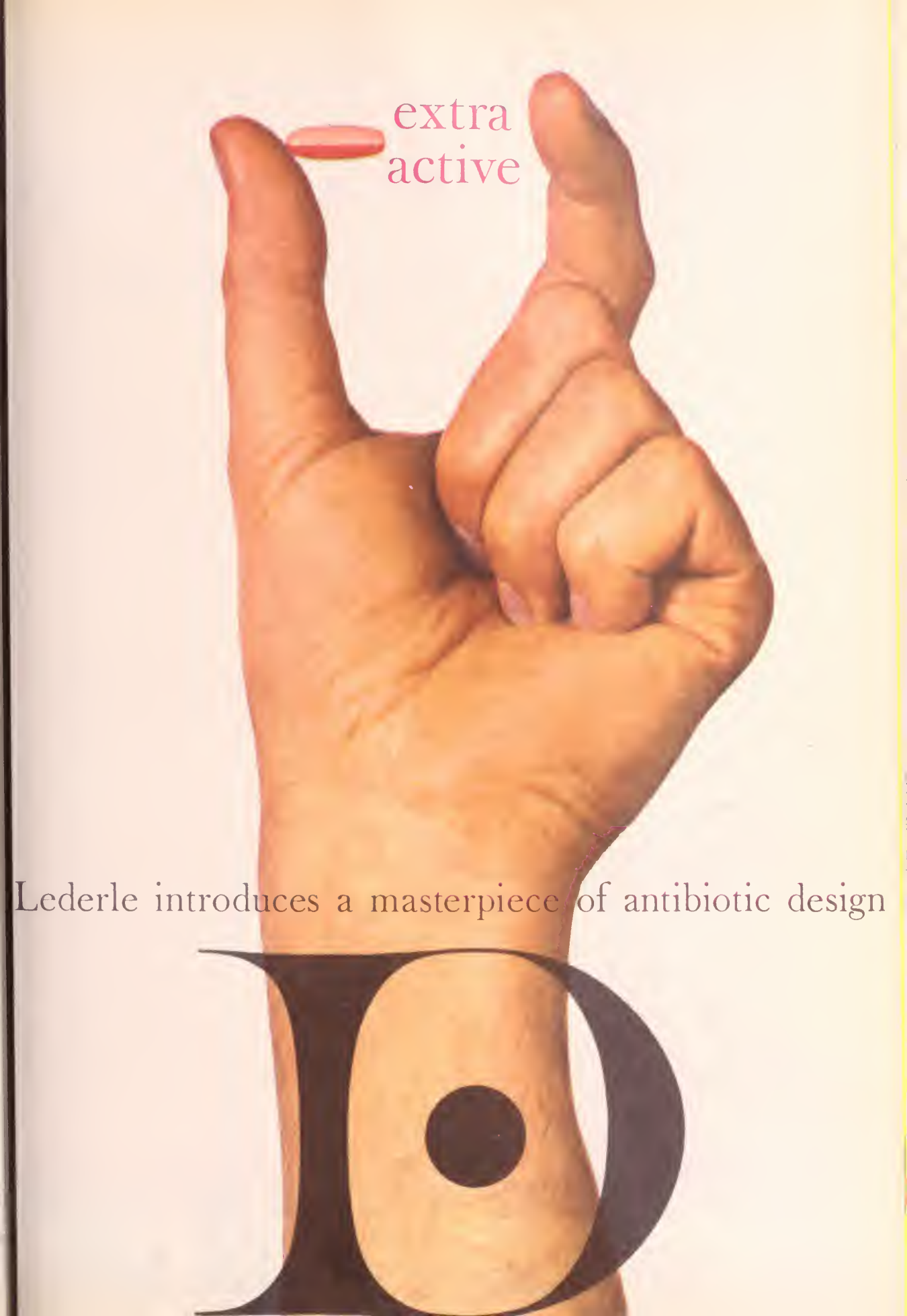
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Actually, DECLOMYCIN demonstrates the highest ratio of prolonged activity level to daily milligram intake of any known broad-spectrum antibiotic. Reduction of milligram intake of drug reduces hazards of related physical effect on intestinal mucosa or interaction with gastrointestinal contents.

*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value.[t]

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The high level of DECLOMYCIN activity is uniquely sustained. It is not just an initial phenomenon but is constant—maintained on each day of treatment and between doses—without noticeable diminution of intensity. Peak-and-valley control is eliminated, favoring continuous suppression of pathogens and consequent improvement.

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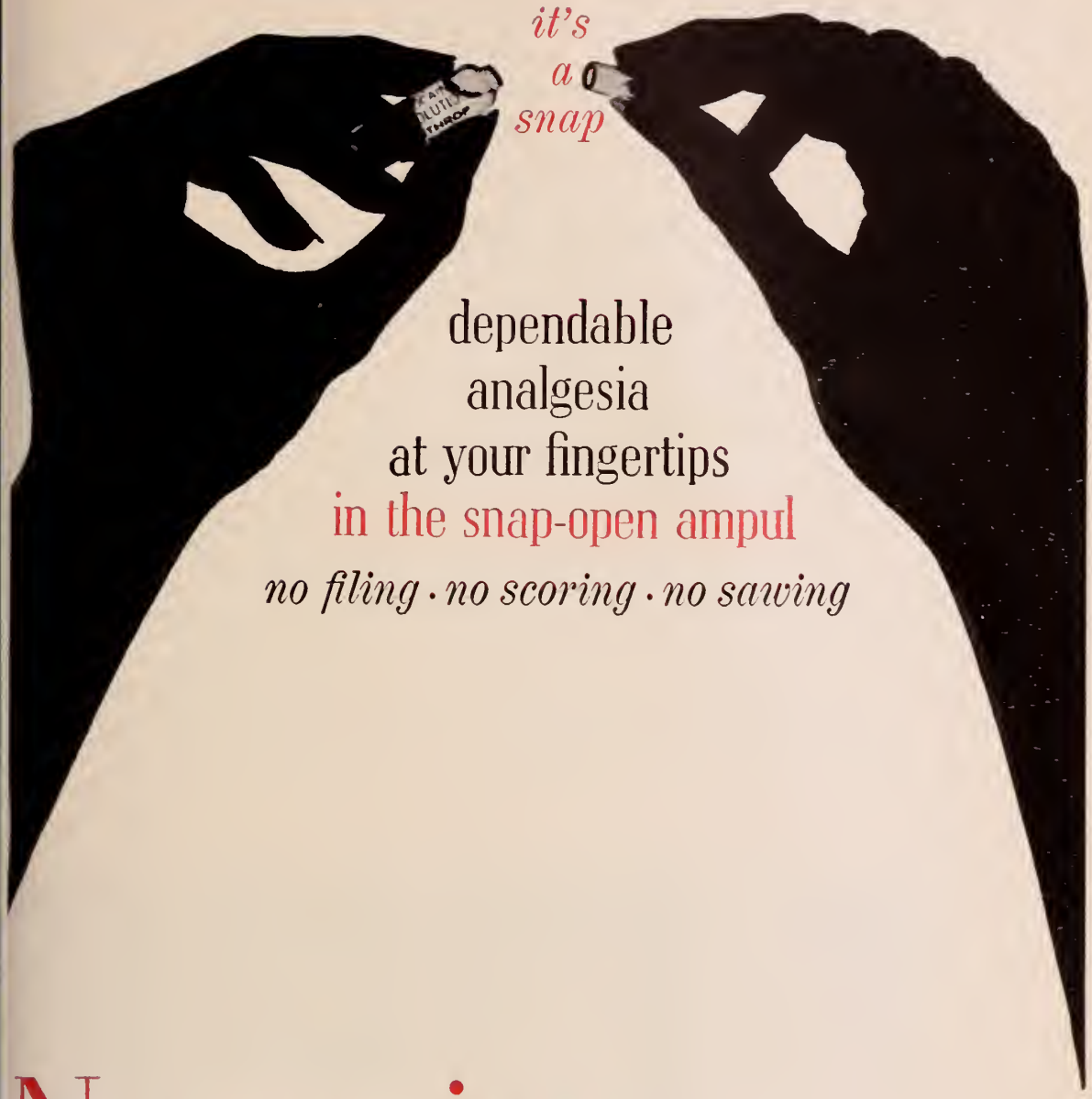
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new hope for fetal salvage

DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long-acting.

According to Tyler and Olson,[5] "These qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone . . . ."

DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABORTE



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Garden City, N. Y.



Amy Sue Greenman
Lincolnwood, Ill.



William Peller
Skokie, Ill.



Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knudsen
Norwich, Vt.

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H.W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

LUTIN

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SQUIBB HYDROXYPROGESTERONE CAPROATE

DELALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

ELALUTIN is also potent and safe therapy for: threatened abortion: postpartum after-ains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated ith genital malignancy; infertility with inadequate corpus luteum function; production of ecretory endometrium and desquamation during estrogen therapy; premenstrual tension; ysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

dministration and dosage:

ecause of its low viscosity, Delalutin may be admin-tered with a small gauge needle (deep intragluteal njection). Complete information on administration nd dosage is supplied in the package insert.

Supply:

Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

of these healthy, normal babies was born by a mother with a documented previous history ue habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



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provides therapeutic sulfa levels for 24 hours... Highly soluble in acid and alkaline media... rapidly absorbed, producing fast, effective plasma-tissue concentrations sustained for the entire day. Simple, single 0.5 Gm. daily dose minimizes patient dosage confusion. At least equivalent to 4 to 6 Gms. daily of previous sulfonamides. Does not produce renal complications.[1]

with low incidence of sensitivity reactions... KYNEX is extremely low in toxic potential.[2,3] Cutaneous or other objective sensitivity reactions are rare, as demonstrated in a large scale evaluation of clinical toxicity.[2] Also minor subjective reactions are less likely to develop when the recommended dosage is used.[2]

Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first-day dose of 1 Gm. (2 tablets).

TABLETS, 0.5 Gm., Bottles of 24 and 100.

also available—KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz.

1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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Supplied: Compocillin-VK Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. When reconstituted, each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

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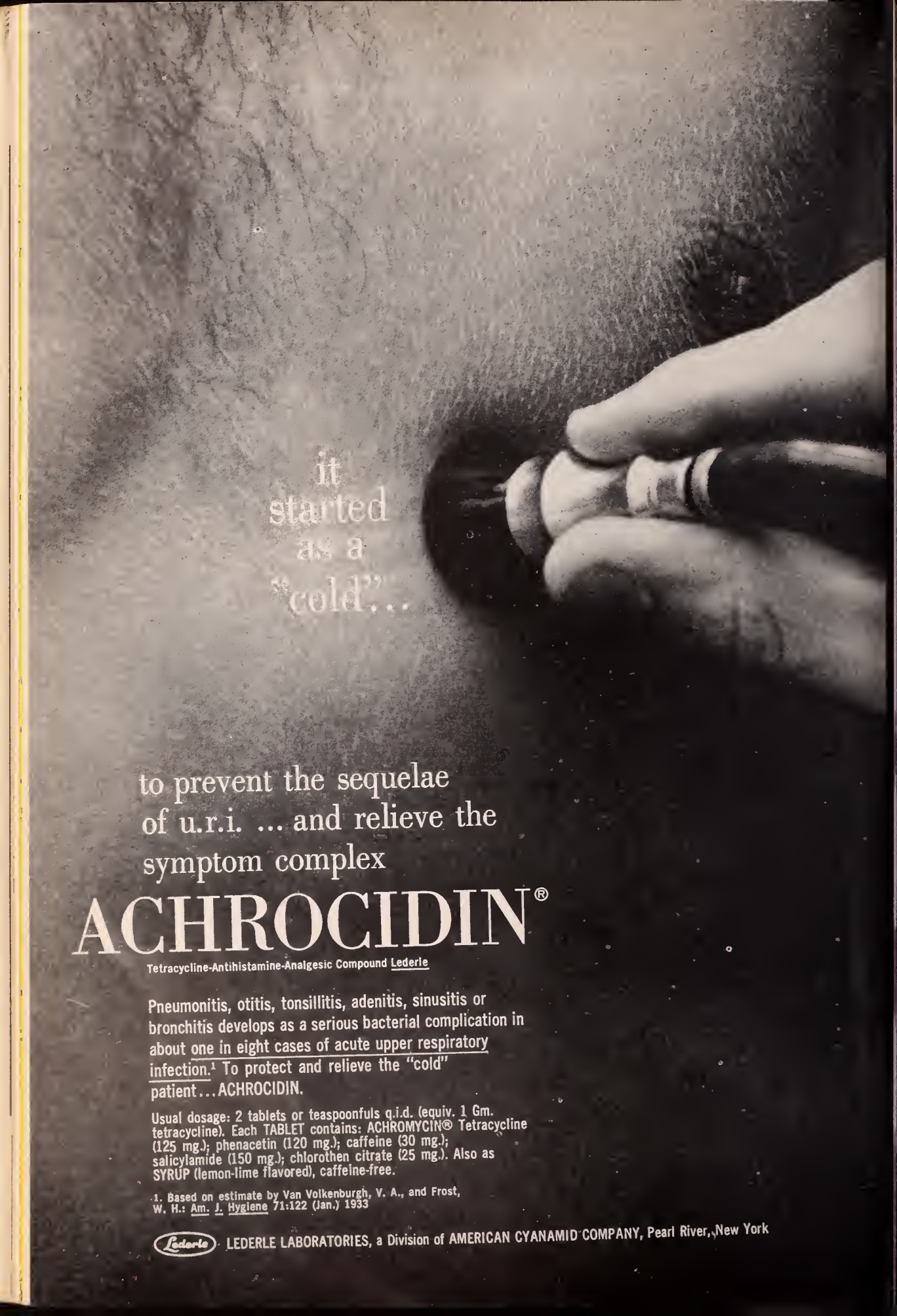
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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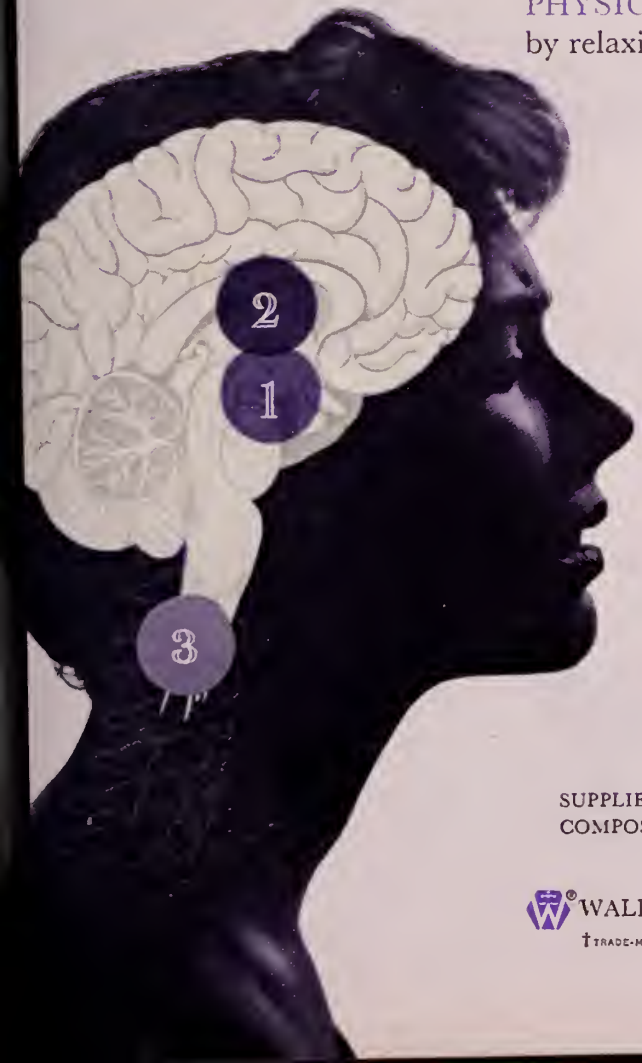
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RELIEVES DEPRESSION
including symptoms such as crying, lethargy, loss of appetite, insomnia

RELIEVES ASSOCIATED ANXIETY
with no risk of drug-induced depression

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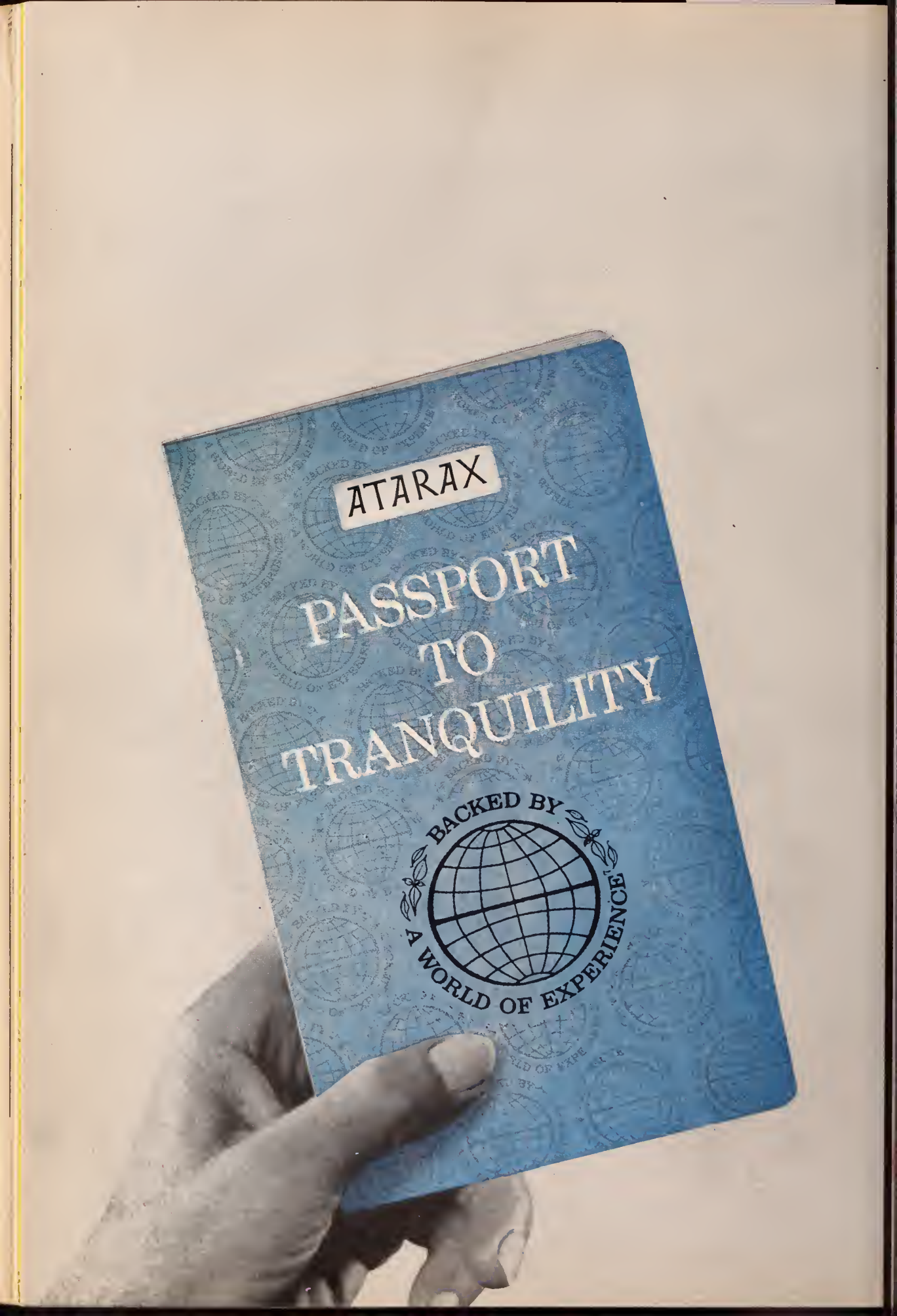
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References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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1. J.A.M.A., *170*:184 (May 9), 1959.

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THE JOURNAL
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Editorials • • •

The Crumbling Cordon of Confidentiality

Elsewhere in this issue is a statement from the U. S. Department of Health, Education and Welfare on the confidentiality of medical reports sent to them. See page 636.

The gist of the matter is that if a claimant is denied a benefit under Social Security or disability insurance he is entitled to see the medical report on which this denial is based.

This puts the doctor on the horns of a dilemma. If he refuses to issue a statement, his patient may be denied any benefit. If he issues a truthful statement which the patient can look at, this may cause ill-will between doctor and patient. The physician under these circumstances might be tempted to say: "a plague on both your houses."

While such a reaction is understandable, it is not in concordance with a doctor's responsibilities. Furthermore, this is merely one more aspect of third party coverage. A large proportion of doctors' bills today are paid by third parties: Blue Shield, Veterans Administration, labor union insurance plans, retirement boards, welfare agencies and the like. If these agencies pay the bill they want to know the diagnosis. There is no escape from this. It is unlikely that we are ever going to see any return to the days where most people paid doctors out of their own pockets and thus assured themselves of a truly "private" relationship.

Perhaps this will lead to a kind of medical double talk. You cannot brand the patient a malingerer because he may see your report. So you say, instead, that you are unable to find any medical evidence to account for the symptoms. It is possible to designate alcoholism under a euphemism and even venereal diseases can be described in long medical terms that seem much less stark than syphilis and gonorrhea. But these are only subterfuges.

To collect your bill, you fill a form. This is delivered to an office where a mail clerk opens the envelope and glances at the form. It then is carried to an "In" basket, and reviewed by a clerk at a higher echelon. It

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reaches another tray where a reviewing authority validates the payment of the bill or relays the form to a medical official for determination. And so Mr. Mayor's hemorrhoids or Miss X's trichomonal vaginitis are thus noted by a bevy of clerks.

A citizen's health is not the only aspect of life where private affairs can become public displays. Any one can get your name from your automobile license tag. In some places, commuters carry tickets with their pictures and addresses. And your income, once a secret between man and wife, is now on record so that a corps of clerks may cluck over it.

Once there was built a dike of confidentiality between doctor and patient. It is not coincidence that the words "confidence" and "confidentiali'y" sound so much alike. The dike is crumbling; there is no escape from the fact that he who pays the piper calls the tune.

The Collapse of General Practice in Britain

Lately, popular magazines in this country have published articles praising National Health Service in Great Britain. The thesis is that, in spite of some limitations, overall medical care for the British people is better now than it was before the second World War. One reason is the enormous proportion of the population now cared for in inpatient and outpatient departments of hospitals. In 1958 there were more than 11 million visits to hospital outpatient departments for minor injuries readily treatable in private offices. Expert testimony on the subject comes from Dr. E. Geiringer whose paper (*The Decapitation of General Practice*) appears on page 1039 of the May 16, 1959 issue of *Lancet*. The paper is more fully abstracted on page 150/1838 of the August 8 (1959) Journal of the American Medical Association. Dr. Geiringer's position on the "capitation fee" for general practitioners is expressed as follows:

"Payment by capitation encourages doctors to do less and less for more and more patients. Three results of the nationalization of medicine," the author said, "are bad practice, the utility-type practitioner, and the hospitalization of medical practice.

"The bad practice falls below all reasonable professional standards. It is conducted from antiquated and badly maintained offices, examinations are perfunctory, equipment is outmoded, no proper records are kept, and treatment consists of the indiscriminate renewal of prescriptions for a dozen standard mixtures. Under the per capita system of payment this type of 'pauper medicine' is profitable.

"The utility practitioner is competent, honest, and hard-working. Having accepted the realities of the NHS he tries to make the best of it by having as many patients as possible on his list. The time per patient equals the number of hours available divided by the number of patients requiring treatment. By making the latter maximal the time spent on each is minimal. Simple medical care is conscientiously prescribed. A patient needing further investigation is referred to a hospital. The numerous psychoneurotic patients are a great worry to the utility practitioner, because he has no time to listen to them. He is not happy to have on his list people who are ill. His favorite patients are those who never have any need of his services. Pregnant women go to the nearest clinic and babies to the infant welfare clinic. Minor surgery is referred to the nearest hospital. Slowly but surely he loses his skill, knowledge, and interest in medicine.

"As hospitals expand to do the work of the general practitioner, with special departments and staff for this purpose, a vested interest is created. The public now expects all treatment beyond the most simple to be given in hospital. Every year there are 11,500,000 attendances at hospital departments for minor injuries that could be treated by general practitioners but are treated by relatively inexperienced interns. Litigation favors this. If anything goes wrong the general practitioner is

blamed in the courts for not sending the patient to hospital. These considerations apply to other activities that general practitioners have tended to hand over to hospitals and clinics. They include antenatal and postnatal care, deliveries, the care of mother and child, child health, acute infections that could be treated at home, the care of the moribund, and minor psychotherapy. This progressive hospitalization of medical care threatens to abolish general practice. It is encouraged by medical research, which draws the patient from the home into the hospital for investigation. Hypertension, diabetes, pneumonia, coronary disease, and rheumatism, to mention only a few, have become vested hospital interests. If general practitioners are paid for what they do and not for what they do not do there will be a tendency for them to use modern medical techniques and keep up to date, because then the best practitioners will attract the most patients. There is no reason general practitioners should not do their own diagnostic radiography and electrocardiography; supervise anticoagulant and steroid therapy; stabilize hypertensive, diabetic, and epileptic patients; and treat patients with pneumonia, acute infections, and coronary disease in the home or in the local hospital.

"Under the capitation system the introduction of new methods, technics and investigations into general practice results in pecuniary loss to the doctor because it has to be financed by him. Every day general practice loses something to the hospitals and in return gains nothing. *Great Britain now has the most restricted and out-of-date form of general practice of any English-speaking country. The general practitioner has become merely a signer of certificates and a hospital signpost.*

The author made a plea for the resurgence of private medical practice, which would exert a healthy influence on the hospital service and safeguard professional freedom. A salaried service is not the answer! Although it would abolish "headhunting," it would not allow patients freedom to choose their doctors. A bad doctor would still be paid as much as a good doctor. A fee-for-service system would rehabilitate the present moribund service by the working of economic laws. As it is more economic to treat patients in general practice than in hospitals, funds could be diverted from them to an enlarged, better paid, and more efficient general practitioner service. Overtreatment is one of the objections to a fee-for-service system, but this could be checked by making the patient pay a part of each fee charged. Other measures to encourage general practice would be increased facilities and financial incentive for home treatment and general practitioner appointments in local hospitals.

The Risk of Telling the Truth

A woman had some blisters following x-ray exposure. A radiologist said that the blisters should be checked at intervals because "cancer might develop." This gave the patient a lot of anxiety. She sued the original doctor. What disability did she claim? The burned shoulder and the blisters? Not that so much—the anxiety, she said, was her major disability. The award was $10,000 for the blisters plus $15,000 for the "cancer phobia." Two higher New York courts sustained the verdict.

Thus is opened a new field of liability. A patient has a head injury and the doctor urges a skull x-ray. Suppose the patient refuses the x-ray and the physician reminds him that the accident might have caused a fractured skull —better take an x-ray to find out. Is the doctor now liable for having caused a fracture-phobia? This doctrine puts the doctor in a "damned if he does and damned if he doesn't" dilemma. Thus, a blood transfusion is being considered. The doctor either (a) warns the family that sometimes there are complications;

or (b) remains silent about complications. If he elects (a) then, under this doctrine, he might be liable for the fear-of-transfusion that it causes. But if he elects (b) and the patient *does* get an untoward result, then he might be liable for having obtained consent without warning the patient of all possible dangers.

No matter what laboratory test the doctor orders, the patient might be frightened at its implication. "Why a blood count, doctor . . . do you think I'm anemic?" If the patient develops an anemia-phobia, is the practitioner liable? If the physician does *not* order the blood test, might he be held negligent?

All these hazards would seem to lie in wait no matter how conscientious the doctor. In fact, the conscientious physician is more likely to be booby-trapped by this than the casual doctor. Not only that, but it will invite assertions of anxiety when there is no real phobia at all. And in the hands of juries will be the problem of deciding when a phobia is genuine and how severe it is.

One must wonder where this strange doctrine will end. The law has an honorable heritage and stands as a monument to the brilliant labors of many centuries of dedicated jurists and advocates. But is the end-product of all that intellectual analysis to be this doctrine of absolute liability for the emotional effects of one's comment? Next time you see a friend, don't say: "Haven't you lost weight lately?" For whether he is too fat or too thin, such a remark may start him worrying. And that can be pretty ruinous to any of us.

Surely the agile and analytic legal minds of our country can come up with a more reasonable doctrine than that.

Blue Shield Accepts the Challenge

Seldom before has medicine earned such a "friendly press" as greeted the recent action of the A.M.A. House of Delegates at its Minneapolis meeting when it resolved that "the A.M.A., the constituent and component medical societies, *as well as physicians everywhere,* expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income" . . .

To make such a program possible, the A.M.A. Delegates urged "that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

Thus, American medicine has forthrightly accepted the challenge of the Forand Bill and acknowledged the special needs of our older citizens, many of whom are getting along on extremely modest retirement incomes.

The national association of Blue Shield Plans has responded promptly to the A.M.A. action. Its staff, under the direction of a special committee, is developing a pattern of coverage, payments and subscription rates that can be used by local Blue Shield Plans in developing their local programs for senior citizens.

Each of us will soon have an opportunity to take part in this great professional enterprise. For it will be up to us, as individual physicians, to make good this A.M.A. pledge. We will be called on for a new and crucial demonstration of the ability of our free profession to meet its collective responsibilities by voluntary action in a free society.

Original Articles • • •

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Joint Changes in Early Malignant and Hematologic Diseases*

In this New Jersey climate, joint pains are often treated lightly as some kind of "rheumatism" or "sciatica" due to meteorologic conditions. But, as Dr. Sperling here points out, joint pains may be the pilot of serious systemic illness.

MUSCULO-SKELETAL symptoms are frequently the first presenting signs of systemic diseases. This is especially important in serious illnesses where early diagnosis may be a life-saving measure. Over a period of years a group of patients have been observed with various forms of blood dyscrasias and malignancies who exhibited joint phenomena. These manifestations were in two groups: one with joint changes occurring *prior* to the onset of the disease picture; the other with joint changes *during* the course of the illness.

The importance of these joint changes seemed evident when the clinical picture became an aid in early diagnosis. The relationship of these phenomena has not been stressed in medical texts and articles. The purpose of this paper is to indicate from personal experience and a review of reported cases, the different disease states which exhibit these changes. In addition an attempt will be made to categorize the joint phenomenon in the different disease states where they follow a distinct pattern.

The table indicates the types of blood dyscrasias and malignancies where these changes occur and also the correlated joint phenomenon.

CLASSIFICATION

1. BLOOD DYSCRASIAS

Disease	Joint Disease Simulated
A. Hemorrhagic Disorders	
1. Hemophilia	Monarticular synovitis
2. Purpura rheumatica (Schonlein)	Migratory arthralgias Polyarthritis
3. Thrombotic thrombocytopenic purpura	Rheumatic fever Polyarthritis Atypical arthritis
B. Pernicious Anemia	Gout Neuropathic joint
C. Polycythemia Vera	
1. Primary	Osteoarthritis Fibrositis (muscular) Gout Neuralgia Chronic arthritis
2. Secondary	Gout
D. Leukemia	
1. Acute	Rheumatic fever
Lymphocytic	Polyarthritis
Granulocytic	Spondylitis
Undifferentiated	Gout
2. Aleukemic	Rheumatic fever
3. Chronic	Rheumatoid arthritis
Myelogenous	Spondylitis Gout
Monocytic	Polyarthritis
E. Hereditary Hemoglobinopathies	

*Presented before the Section on Rheumatism, Annual Meeting of The Medical Society of New Jersey, April 29, 1959.

1. Sickle cell disease	Rheumatism Rheumatic fever Rheumatoid arthritis
2. Homozygous Hemoglobin C disease	Arthralgias Gout
3. Sickle cell D disease	Rheumatoid arthritis
4. Miscellaneous	
Sickle C	Arthralgias
Sickle G	Polyarthritis
Thalassemia S	
Thalassemia F	
F. Miscellaneous Disorders	
1. Infectious mononucleosis	Neuritis Rheumatic fever
2. Erythremic myelosis	Rheumatoid arthritis
3. Agnogenic myeloid metaplasia	Gout
4. Chronic hemolytic disorders	Gout
Congenital hemolytic disease	
Erythroblastic anemia (Cooley's)	
G. Multiple Myeloma	Osteoarthritis—spinal Disc syndrome Rheumatoid arthritis Arthralgias

2. MALIGNANCIES

Disease	Joint Disease Simulated
A. Hypertrophic Pulmonary Osteoarthropathy	
1. Pulmonary carcinoma	Rheumatoid arthritis
2. Pleural mesothelioma	Arthralgias
3. Fibrosarcoma of lung	Rheumatic fever
B. Lymphoma	
1. Hodgkin's disease	Rheumatoid arthritis
2. Giant follicular lymphoblastoma	Gout
3. Reticulum cell sarcoma	Arthralgias
4. Lymphosarcoma	Palindromic rheumatism
C. Sarcoidosis	Arthralgias Still's disease Rheumatoid arthritis Palindromic rheumatism Erythema nodosum Rheumatic fever
D. Carcinomatosis	
1. Neuromyopathies	Neuralgia Fibrositis
2. Metastases	Spinal osteoarthritis Radiculitis
E. Carcinoid Tumors	Rheumatoid arthritis

HEMORRHAGIC DISEASES

1. *Hemophilia* manifests itself by acute hemarthroses which may absorb rapidly without joint damage or may lead to marked joint destruction and the chronic changes resembling destructive severe arthritis. Diagnosis is usually easy and is apparent due to the bleeding tendencies which show up from childhood on. In a few patients, the first manifestation of the disease is a hemarthrosis. There may have been minor bleeding episodes which were overlooked so that no diagnosis was made prior to the acute monarticular involvements. The diagnosis is readily made by arthrocentesis. However, without a diagnosis there may be repercussions due to inadvisable surgery.

2. *Purpura rheumatica* (*Schonlein's purpura*): This is part of the idiopathic or anaphylactoid purpura group which includes purpura simplex, Henoch's or visceral purpura and the Schonlein or articular type. Derham[1] reported 35 cases with joint symptoms in twenty. The type of changes moved from transitory arthralgias to migratory polyarthritis and occasional effusions. There are no residual joint changes. All laboratory studies are normal. The condition is recurrent and occurs more in the young so that at times a differentiation from rheumatic fever or an early rheumatoid arthritis may be necessary.

3. *Thrombotic thrombocytopenic purpura* is a rare but serious disease. It is also known as the "platelet thrombosis syndrome." It resembles lupus in its disseminated manifestations and has diverse signs as fever, hemolytic anemia, thrombocytopenia purpura, neurological changes, and hyaline-thromboses of minute vessels. There have been descriptions of rheumatic and arthritic signs and symptoms of a vague nature during the course of the disease but no definite or specific picture. A case reported by Robinson[25] describes an infant with this clinical state. The chief presenting symptoms were fever, a vague rash and painful swollen wrists and ankles. Thus the early diagnostic picture may resemble a rheumatic fever or early atypical rheumatoid arthritis. However, the true clinical picture manifests itself soon after the onset, and the disease is usually fatal.

PERNICIOUS ANEMIA

THE clinical picture of this disease is well documented but the joint changes (which are uncommon) have not been greatly stressed. The recognition of these changes in association with pernicious anemia is not always apparent since present day vitamin therapy often masks the underlying disease.

The types of joint changes in pernicious anemia include either attacks of gout or a gradual chronic developing neuropathic joint. Both are rare but have been described in the literature. Pennti and Klaus [2] described a neuropathic joint resembling tabes in a series of 52 patients. One patient had severe but typical x-ray and clinical signs. In eleven other patients there were mild to moderate changes in knees typical of this syndrome.

Both the neuropathic joint changes and attacks of gout have no definite predictable sequence, but they must be recognized since they may be the only sign of the underlying disease.

POLYCYTHEMIA VERA

POLYCYTHEMIA vera may be seen as a primary disease as described in the past by Velasquez and Osler. There are also secondary forms which follow such states as congenital heart disease and chronic pulmonary conditions.

There are a large group of joint and musculo-skeletal changes chiefly in the primary form of polycythemia. Many occur as initiating symptoms while others are characteristic during the course of the disease. The basic patterns are as follows:

1. Osteoarthritie
2. Fibrositic (generalized muscle spasm)
3. Gout
4. Neuralgic
5. Generalized joint pains and limitation of motion

Damashek and Henstell[3] reported several cases with a 5-year history of generalized pains which were diagnosed as "chronic arthritis" before the true disease picture was discovered. He also described joint changes with deformities. Others have described gout as a common occurrence and this will be discussed below.

Two patients seen by the author exhibited the severe chronic diffuse symptoms. One was called a psychoneurotic for three years before a diagnosis was made. The other had vague neuralgic pains and muscle spasms.

The cause of the joint pains has not been definitely established except in gout where there is probably a degradation of nucleoproteins and precipitation of urates. The other effects are most likely due to pressure on bony structures by hyperplastic marrow. With decreased blood counts many show a marked improvement in symptomatology.

Joint changes in secondary gout are apparently rare from reported cases. However, gout was described by Yu[9] in a patient with congenital heart disease with typical x-ray changes, bursal changes, tophi and severe attacks of classical gout.

LEUKEMIA

THERE are many joint symptoms and changes during the course of the various forms of leukemia. The chief clinical pictures may be classified as resembling the following:

1. Rheumatic fever type
2. Aeute polyarthritis
3. Gout
4. Spondylitis
5. Hypertrophie pulmonary osteoarthropathy

The relationship of the various types to the forms of leukemia is indicated below. Rheumatic symptoms are correlated with the various pathologic changes in leukemia including tumor formation, periosteal elevation, leukemic infiltration in juxta-articular bone, osteosclerosis, and bone destruction. Thus many symptoms are due to the mechanical effects of these infiltration processes. However, other forms such as polyarthritis are due to a general toxic effect and gout to protein degradation.

1. *Acute leukemias* usually occur in the young and exhibit predominant bone and joint pains[5] in at least a third of the patients. The association with fever, weakness and other symptoms simulates rheumatic fever. The presenting picture frequently is not diagnosed as

a leukemia until the severe course predominates and frequently early death occurs. In infants under 3 years of age, polyarthritis without carditis usually means leukemia.

Although the morphology is frequently not evident in the acute forms of leukemia, there have been reports of joint changes in specific types, such as acute lymphocytic leukemia.

Two elderly patients with acute leukemia were observed with acute joint phenomena. One 68-year old man was treated for three months for typical signs and symptoms of acute spondylitis. He had a progressive downhill course and died in a short period thereafter. Various studies revealed acute leukemia with a low total count picture. The other patient, a 70-year old male, developed an acute arthritis like a rheumatoid arthritis. A severe anemia rapidly developed and he died in three months following onset. Studies of the blood revealed an acute granulocytic leukemia.

2. *Aleukemic forms of leukemia* may occur without typical blood changes. Bone and joint pains and fever in these cases may suggest rheumatic fever or early rheumatoid arthritis.

3. *Chronic leukemias*: There may be no joint or bone symptoms in these cases. However, various forms of the chronic state exhibit different rheumatic pictures. Dresner [4] reported a case of adult monocytic leukemia which presented as an acute polyarthritis with swelling and effusion in the large joints. An autopsy illustrated infiltration of leukemic stem cells in the synovia.

Gout has been described in all forms of leukemia and is discussed below.

One patient was seen with a picture of a spondylitis or a disc syndrome for a period of a year before a diagnosis of chronic myelogenous leukemia was made. With suppressive therapy the spinal symptoms disappeared only to recur with the flare-up of the leukemia. This repeated on six occasions until the death of the patient.

Another patient with chronic granulocytic leukemia [11] over a 5-year period developed acute polyarthritis with effusion and joint inflammation during each recurrence of leukemia.

Thus leukemia may simulate all forms of arthritis and in many cases the presenting symptoms may be rheumatic. An awareness of this fact may aid in an earlier recognition of leukemic states and an earlier institution of appropriate therapy.

HEMOGLOBINOPATHIES

IN RECENT years there has been a voluminous literature describing all of the forms of the hemoglobinopathies which have been differentiated by the use of the electrophoretic separation of various types of hemoglobin. Basically these are chiefly hemolytic diseases and many of the signs depend on typical hemolytic crises. However, some forms have chronic symptomatology with mild rheumatic manifestations. Many of these diseases, except sickle cell disease, are uncommon but all have some rheumatic manifestations.

1. *Sickle Cell disease usually occurs in Negroes.* It may exist as a trait without symptoms in 9 per cent of Negroes and in one in every 40 it is in the form of the true disease or "Homozygous Sickle cell disease" due to large amounts of hemoglobin S. This leads to crises involving the abdomen, muscles and joints as well as hemolysis. Thus it may show itself as a joint disturbance when the other symptoms are not prominent. Thus there may be aching pains in the joints and extremities which are called rheumatism. In addition, some patients may have swelling and signs of joint inflammation but this is rare. Thus the picture may resemble rheumatic fever or rheumatoid arthritis. In addition, gout may occur and has been described by Aquilina.[7] This is important since gout is considered rare in the Negro.

2. *Homozygous Hemoglobin C disease* has been described [12] in a 79-year old Negro male with development of gout.

3. *Sickle Cell D disease* was described by Smith [6] in association with a picture resembling rheumatoid arthritis. The history was one of recurrent pain and swelling of the hands and feet with attacks coming every two or three months lasting for several days. Later the patient developed other painful symptoms and was treated as an infectious arthritic until the

chronic hemolytic picture became apparent. During the chronic state he had recurrent periods of disability due to severe pains of a generalized nature.

4. *Miscellaneous forms* such as Sickle Cell C disease, Sickle Cell G disease, Thalassemia-Hemoglobin S and Thalassemia F disease may all give mild bone and joint pains with arthralgias and occasional crises like sickle cell disease.

OTHER HEMATOLOGIC CONDITIONS

1. *Infectious Mononucleosis* does not have many joint changes except for the generalized aches characteristic of any infection. However, a few develop a neurologic complication in the form of a neuritis resembling the Guillain-Barre syndrome. In the early phases this gives muscle weakness, pains and neuralgic symptoms. This is short-lived and the clinical picture of the neurologic disease becomes evident.

Another small group may resemble rheumatic fever due to the fever and generalized joint pains. With proper diagnostic procedures this, too, is easily differentiated.

2. *Erythremic Myelosis* has been cited as a rare hematologic disorder. In one patient there was a history of joint changes similar to rheumatoid arthritis in its classical picture. This was present for a prolonged period in spite of all therapy towards the blood changes.

3. *Agnogenic Myeloid Metaplasia* has been reported in association with gout and hyperuricemia in 9 cases.[27]

4. *Chronic hemolytic disorders* such as congenital hemolytic disease and erythroblastic (Cooley's) anemia[8] have been reported with accompanying gout and gouty arthritis.

MULTIPLE MYELOMA

Joint symptoms have been described in this condition varying from vague arthralgias, intermittent pains, and marked back and girdle type of pains with radiation into the legs. These may be early signs and frequently are diagnosed as degenerative spinal arthritis or discs.

Davis[24] reviewed 26 cases of myeloma and pointed out the frequent involvement of large joints such as the shoulders and hips as well as the spine, but infrequent signs in the fingers, wrists and ankles. Twenty-two of the patients gave first symptoms as pain in the spine and 16 had a primary diagnosis of arthritis. They described two patients who were treated as rheumatoid arthritics for a long period of time with typical signs and therapy which included such methods as gold, steroids, and so forth.

Other reports in the literature are infrequent but there have been cases cited[25] with a typical rheumatoid type of picture. One of these patients showed typical rheumatoid deformities and x-ray changes typical of rheumatoid arthritis.

I treated one patient with atypical rheumatoid arthritis for a year before evidence of bone changes became apparent and the diagnosis of myeloma was confirmed by biopsy of the pelvic bones. She also showed negative latex-fixation tests and abnormal globulins on electrophoresis. In the past year she still shows active joint symptoms which are proportionate to the underlying disease activity.

In all cases where joint changes have been noted and the opportunity presented itself, amyloidosis was found in the joint structures. This seems to be the generally accepted explanation of these changes in multiple myeloma. It is interesting to note that primary amyloidosis does not have joint involvement.

SECONDARY GOUT

Because of the diverse group of diseases in which secondary gout occurs, it has been treated as a separate entity for coordinating reasons. This refers to gout which is secondary to an underlying disease as contrasted to primary gout which is without basic causal factors. It is also of interest from the diagnostic standpoint that acute attacks of gout may be the first sign of the underlying disease. However these attacks usually occur in the course of the disease and are probably due to the liberation of intermediary purines as well as uric acid from the breakdown of cellu-

lar nucleoproteins. This fact has been substantiated by tagged glycine metabolic studies.[10]

There is also a high incidence of secondary gout in relationship to the therapy of these conditions such as following radiation or Vitamin B_{12} therapy. Hyperuricemia has been reported in association with the therapy of acute leukemia after using 6-mercaptopurines and steroids. The therapy may precipitate acute attacks of gout or accentuate the course of gouty complications.

The treatment of these gouty complications is the same as that of primary gout (colchicine, phenylbutazone, ACTH, etc.). Basically the treatment depends more on relief of the underlying disorder. Some of the conditions in which secondary gout has been known to occur are listed below.

1. Primary and secondary polycythemia
2. Pernicious anemia
3. Leukemia (acute and chronic)
4. Hereditary hemoglobinopathies
5. Hemolytic disorders (Cooley's)
6. Myeloid metaphasia
7. Hodgkin's disease
8. Myeloma

The incidence of gout in these disorders is not rare and reports have accumulated in the literature of more than just chance occurrence. In polycythemia there is an incidence of between 5 and 7 per cent of gout.

PULMONARY OSTEOARTHROPATHY

THIS condition was described in 1889 by Bamberger and later by Pierre-Marie as an ossifying periostitis. The cause is unknown. The condition usually occurs secondary to chronic lung suppuration, thoracic tumors, congenital cardiac disease, polycythemia, liver cirrhosis, thyroid carcinoma, chest wall tumors, leukemia, colitis and fibrosarcoma. The effects are those of clubbed fingers with subperiosteal symmetrical proliferation of the long bones of the arms, legs, clavicles, ribs and pelvis. This results in a periostitis and periosteal thickening as well as a synovitis. The joints of these patients exhibit a chronic non-specific synovitis associated with degeneration of articular cartilage.

Joint lesions occur in one-third of these patients in various stages. These may be simple arthralgias up to arthritic changes which resemble rheumatoid arthritis, or rheumatic fever.

This group is of special interest here because many cases of pulmonary neoplasm may have manifestations which are indistinguishable from early rheumatoid arthritis. Varvinen [13] reviewed a large series of patients with rheumatoid arthritis and another group with carcinoma of the lung. He pointed out the fairly high incidence of joint symptoms and signs resembling rheumatoid arthritis. Many of these predated the lung pathology for prolonged periods of time. They characteristically were called atypical rheumatoid arthritis and showed rapid deterioration of the patient. This was most evident in a patient whose lung pathology was not discovered until an autopsy was performed. Temple and Jaspin [16] reported 12 cases with a diagnosis of rheumatoid arthritis for varying periods of time. Eight of their 12 patients had joint symptoms before the hypertrophic pulmonary osteoarthropathy was discovered. Most of their patients had carcinoma of the lung but one had chronic myelogenous leukemia. Patterson [15] also reported a similar relationship in six patients.

In a review of 1024 cases [17] in which pulmonary resection was performed there were 61 cases with arthropathy. These included a 57 per cent incidence in pleural mesothelioma, and a lesser incidence in bronchiectasis, lung abscess, pulmonary cysts, malignant tumors and tuberculosis. However, except for the more acute rheumatic symptoms of the malignant and mesothelioma group, there were basically minimal arthralgias. He summarized other reports as well as his own large series (495) and noted an incidence of 6 per cent with joint symptoms. Half of these had acute symptoms resembling rheumatoid arthritis and many preceded the pulmonary disease for periods up to several years.

Symptoms may include pains, arthralgias, tender joints, synovial swelling and increased fluid. These may be slow in development or occur as an acute process.

Frank [14] and others have pointed out the rapid relief of the joint phenomena after resection for pulmonary neoplasms. The relief

may occur in a few days and clear completely in three months. The symptoms may also recur when the tumor exacerbates. This phenomenon is still unexplained as is the etiology of this condition. However, it is not related to any metastatic process.

Temple [18] reported a case of fibrosarcoma of the lung with a preceding 9-month history of pains in multiple joints with swelling associated. With surgery the symptoms disappeared and in two months x-rays revealed a clearing of the bony changes of hypertrophic pulmonary osteoarthropathy.

I have had the opportunity to observe ten patients referred for symptoms of rheumatoid arthritis. All had acute joint inflammation with swelling of multiple joints but particularly the elbows and wrists. All were classified as atypical rheumatoid arthritis. With a negative latex-fixation test and an abnormal protein electrophoresis, further studies were indicated which led to the diagnosis of pulmonary neoplasm. These symptoms preceded the final diagnosis by periods from 1 month to 18 months. Thus, an early diagnosis is possible when one is conscious of this diagnosis in an atypical rheumatoid arthritis. Certainly, any patient with joint symptoms and symptoms referable to the chest must be considered a potential pulmonary neoplasm or mesothelioma.

LYMPHOMAS

THIS group which contains Hodgkin's disease, reticulum cell sarcoma, lymphosarcoma and giant follicular lymphoblastoma may give various types of joint changes which include the following clinical pictures.

1. Rheumatoid arthritis
2. Arthralgias
3. Gout
4. Palindromic rheumatism

Basically most cases have been described in Hodgkin's disease, and the varied findings have been reported in this condition. The bones are involved in 50 per cent of the cases of Hodgkin's disease. This has been explained on the basis of direct invasion from adjacent granulomas, hematogenous spread or some agent which acts as an irritant. These may give osteolytic, osteoblastic, or periosteal lesions, all of which may give symptomatology.

This picture resembling rheumatoid arthritis in Hodgkin's disease has been reported by Davis,[24] and other symptomatology by Coles.[22] The latter also described joint changes in 2 cases of reticulum cell sarcoma which were the early presenting signs.

One patient was observed with a reticulum cell sarcoma who presented a typical picture of rheumatoid arthritis in multiple joints for 6 months before developing severe backache. X-rays and a biopsy confirmed the diagnosis of reticulum sarcoma. With x-ray therapy the lesion cleared and all joint signs disappeared. The bone lesions recurred 6 months later and at the same time all joint symptoms recurred.

CARCINOMATOSIS

Neuromyopathies have been described as one of the effects of carcinoma particularly of the lungs but it may also occur with other primary sites such as the ovary, prostate, rectum and breast or undetected sites. The symptoms are not due to direct tumor encroachment, but to some unexplained factor. They may occur before the onset of the tumor or even after surgery. The symptoms resembling rheumatic states are vague but stem from the myopathies or neuropathies. Thus, they may resemble a neuralgia or a fibrositic picture.

Metastatic Bone Carcinoma: One of the most frustrating experiences in the care of patients is the discovery of a metastatic carcinoma with an undetected primary source. It is a common experience in treating patients with rheumatic disorders to be the discoverer of such diagnoses. Many patients first became aware of the presence of a malignancy by complaints referable to the back from bone metastases. This is common in carcinomas of the breast, prostate, lung, adrenals and thyroid. The metastases are common in the spine in the medullary portion of the bone. They are destructive and cause severe and unremitting pain. These symptoms are unaided by bed rest

and most medications. It is almost axiomatic that back pain in a patient after 40 that is unrelieved by rest is usually due to malignancy.

Many of these patients present pictures which resemble a degenerative arthritis of the spine frequently associated with radicular pain into the legs. They are also commonly confused with a herniated disc. X-rays of the spine are frequently negative for a long time after the symptoms commence. For these reasons the primary diagnosis is often overlooked and they are treated with various therapeutic measures which are usually ineffective.

A large group of patients (25) have been treated who fit into this category. Most were due to carcinoma of the lung but some fall into other categories. Each presented unremitting pain unrelieved by rest or therapy. One-half of the group had negative x-ray findings until the symptoms were advanced. With this sort of picture one should make a concerted search for a primary malignancy usually in the lungs. The important factor is the doctor's alertness to the possibility of malignancy in this type of patient.

CARCINOID TUMORS

These have been described fully in recent years. Classically they are usually located in the distal ileum and may produce malignant metastases. These produce a group of classical symptoms often described as due to excess secretion of serotonin. Among the symptoms are flushing, hypotension, diarrhea, enlarged nodular liver and asthma. Arthritic symptoms have been described in this syndrome and at times the picture has resembled rheumatoid arthritis.

SARCOIDOSIS

Joint changes in sarcoidosis occur more frequently than has been stressed in medical writings and teachings. The disease itself, due to its protean manifestations may easily be misdiagnosed. Joint and rheumatic symptoms may include clinical pictures resembling any of the following:

1. Generalized arthralgias
2. Still's disease
3. Rheumatoid arthritis
4. Palindromic rheumatism
5. Erythema nodosum
6. Rheumatic fever

The acute process with generalized symptoms including fever and active signs of inflammation may be responsible for the frequently reported arthralgias. However, these are non-specific and of no great diagnostic importance.

Castellanos [21] reported a case in a 6-year old child which resembled Still's disease. This lasted for four years before a true diagnosis was made by a biopsy.

This has a fairly high incidence of bone involvement particularly of the phalanges of the hands and feet. There is a formation of bony nodules which consist of diffuse coarse reticular bone destruction. These thus resemble bone cysts and the location of these lesions often account for symptoms which are called atypical rheumatoid arthritis. The deformities may be large in these patients with little functional impairment as contrasted to the typical rheumatoid arthritic. However, they may simulate fusiform swelling and give typical symptomatology.

Sokoloff and Bunim [19] stressed the occurrence of polyarthritis in patients with sarcoidosis. The joint change frequently preceded the true disease process or was associated with the early disease. The areas involved were either the large or peripheral joints and they were associated with pain, swelling, warmth and tenderness. However, there was no joint destruction and the adjacent bones were not involved with sarcoidosis. Other authors have also pointed out this picture of polyarthritis which was similar to rheumatoid arthritis. However, they stress the non-articular rheumatic symptoms as more frequent than the polyarthritis. Favour and Sosman [20] in a discussion of erythema nodosum point out the incidence of this condition in sarcoidosis. They stress the occurrence of recurrent attacks of polyarthritis for periods of 1 to 20 years before the onset of the skin lesions. This pic-

ture may resemble a palindromic rheumatism. Erythema nodosum frequently occurs during the course of sarcoidosis. These patients also exhibit fever and migratory joint phenomenon. For this reason they are often diagnosed as rheumatic fever. However, eventually the true clinical picture manifests itself and particularly hilar lymphodermapathy which directs the physician to the proper diagnosis. One patient was observed with the picture of a polyarthritis resembling rheumatoid arthritis for a period of several months. However, the onset of an acute febrile course with typical lesions of erythema nodosum finally led to the diagnosis of sarcoidosis.

SUMMARY

1. Joint and rheumatic symptoms are fairly common in malignant and hematologic diseases.

2. The joint manifestations may be the earliest symptoms of the underlying disease. This is especially true in pulmonary malignancy, metastatic malignancies, leukemia and sarcoidosis.

3. Joint and rheumatic symptoms also occur commonly during the course of the underlying disease.

4. The type of changes and their manifestations may be an aid in early diagnosis of the underlying disease.

32 Johnson Avenue

A bibliographic listing of 27 citations appears in Dr. Sperling's reprints.

Jet Travel Presents Infection Hazards

Rapid air travel presents a danger in the control of infectious diseases, according to Dr. Wesley W. Spink, writing in the April 18, 1959 Journal of the American Medical Association. "In this era of missiles and jet travel a medical problem in Madras, India, today, may be that of New York City's tomorrow." Thus a German physician traveled from India to Ceylon, where he thought that he had contracted influenza. He continued to Switzerland and then to Heidelberg. Shortly thereafter, the physician and at least 13 other persons with whom he had been in contact were given diagnoses of smallpox.

Such spread of a disease has occurred many times in more restricted geographical areas, but "the availability of rapid means of travel could readily expand the area." To make matters worse, many physicians are unfamiliar with diseases not prevalent in their own areas.

Spink suggests that a program be set up as a regular graduate course for physicians, worked out through the U. S. Public Health Service and the World Health Organization. Physicians would be sent to different areas in the world to see diseases under natural conditions.

Many diseases are well controlled in certain areas, such as smallpox in the United States. However, "it is well to recall that in all of the history of medicine *no infectious disease has ever been treated out of existence.*" Even plague still exists in the world, although it rarely breaks out, mainly because of public health measures.

The great advances in the control and elimination of infectious diseases have taken place only because of the accumulation of precise data about the life habits of specific infective agents. Armed with accurate information men have made efforts to block the channels through which disease is spread.

S. G. Bluestein, M.D.
Paterson

A New Oral Cholecystographic Medium

Exceptionally good visualization with a low incidence of side reactions is reported by Dr. Bluestein with respect to bunamiodyl as an oral medium for cholecystography.

In 1925, oral cholecystography was first successfully reported by Graham and Cole.[1] Since that time, great advances in the diagnosis of gall bladder disease prior to surgery have taken place. Tetraiodophenolphthalein was a toxic medium with many side effects, but it was the best substance available until in 1944, it was replaced by iodoalphionic acid.[2] Priodax®, is the registered brand name for the Schering Corporation brand of iodoalphionic acid.

Since that time there has been much research in the field of oral opaques. New products are now being developed regularly which are available to the clinician. Such research, by 1952, produced 3-2 ethyl-propanoic acid. Telepaque® is the registered brand name of the Winthrop Stearns brand of this medium. This has supplanted all other opaques for oral cholecystography.[3] But even this medium produced nausea in at least 10 per cent of patients, and diarrhea of varying degrees in at least fifteen per cent of the patients. So the research continued, but most new products were not superior to Telepaque® and have been abandoned.

Recent studies have been made with 3 (3-butyrylamino-2,4,6-triiodophenyl)-2 ethyl sodium acrylate. Orabilex® is the registered trade name for the E. Fougera and Company, Inc. brand of this substance. Reports indicate that it is superior to other products for general use in both busy hospital departments and private offices. Excellent visualization is obtained with this medium in at least as high a proportion as any other drug now in use, but the number of side effects appears to be smaller. The lessened incidence of residual dye in the intestinal tract makes the examination easier, radiologically, because it avoids conflicting shadows which have complicated interpretation previously.

ORABILEX®

Orabilex® is a tri-iodinated compound, containing 57 per cent iodine. It is a microcrystalline, white powder, slightly soluble in water, having a molecular weight of 660.7. In acute intravenous toxicologic studies in mice, the LD50 of Orabilex® was established at 570 milligrams per kilogram of mouse. In acute oral assays in rats, the LD50 would be 2.2 Grams per kilogram of rat.

Chronic toxicity studies by oral administration in rats and dogs revealed nothing unusual. Groups of the test animals were fed varying amounts of Orabilex® up to a daily dose of 1.5 Grams per kilogram of dog. At the end of the test period the animals were sacrificed and carefully examined for any morphologic changes. Thyroid, liver, kidney, spleen and duodenum tissue were sectioned for histological study with negative findings.

Liver and kidney function tests were performed on each animal prior to and upon completion of the experiment. No impairment of the liver or reduced capacity of the kidney was noted.

1. Graham, E. A. *et al.*: Journal of the American Medical Association, 85:953 (June 1925).
2. Bryan, L. and Pedersen, N. S.: *Radiology*, 42:224 (February 1944).
3. Shehadi, W. H.: Am. Journal of Roentgenology, 68:360 (June 1952).

TECHNIC

At the outset of the study Orabilex® was supplied as a 1 Gram tablet, but this was later changed to a 750 milligram capsule which was easier for the patient to swallow. The usual gall bladder routine is followed. No physic is necessary because of the small amount of residual dye found in the intestinal tract after oral administration. Patients are instructed to have a fat free meal the night before the examination. At 8 p.m. the same evening, they take six capsules with water and then fast until after the examination is completed. An enema is advised at bedtime, but only two-thirds of the patients take enemas.

Three hundred consecutive cases were selected for study. Patients were from three different hospitals and one private office. It is likely that in evaluating the side reactions we have been somewhat prejudicial against Orabilex®, because all reactions were considered due to the drug, even though some of the patients had similar symptoms due to their disease and prior to the examination. Thus the symptoms might *not* have been caused by the drug. It was felt necessary to follow this procedure because it was impossible to differentiate these groups satisfactorily. All patients who did not visualize with a dose of six capsules were given another six capsules on the second day and remained on a fat free diet throughout the entire examination. In all cases studied, the patients had films made in the prone postero-anterior and oblique positions, and were spot filmed with compression in the upright position.

CHART 1.

Visualization		%	%	Stones	%
Excellent	204	68	80	27	9
Good	36	12			
Fair	21	7	20	12	9
Poor	12	4		9	
None	27†	9		6	
Total	300	100	100	54	18

†All patients who did not visualize in the original examination, received a second dose of 6 capsules.

Interpretation

As indicated in Chart 1, 80 per cent of the examinations showed excellent or good visualization; and of that percentage, 11 per cent showed stones. In the 20 per cent of cases where the gall bladder was considered pathological (either because of unsatisfactory or non-visualization) 45 per cent still showed stones.

CHART 2.

Reactions

Number of patients studied	300
Number of patients having reactions	21
Nausea	15
Vomiting	15
Diarrhea	6
Dysuria	6
Cramps	6
Subcostal pain	1
Hives	1

Interpretation

As indicated in Chart 2, only 7 per cent of patients had reactions to Orabilex®. Nausea and vomiting were the most common complaints. Not all the patients who had nausea vomited. Several who did not had only very mild nausea. All of the patients who complained of diarrhea and cramps also had nausea and vomiting. Of the 21 patients who complained of side reactions, over half could be classified as mild. In no case was it necessary to discontinue the examination because of side reactions, although one-third of the patients who had reactions complained of severe nausea, and all vomiting is considered a severe reaction.

Orabilex® is considered an excellent drug for busy departments, because the incidence of non-visualization of the gall bladder is low, and the number of patients requiring second dose studies is even lower. The quality of visualization is such that although concentration is good, it is rarely dense, so the possibility of obscuring small stones is unlikely. At no time during this series were stones visualized by spot compression films that were not seen on the regular films; but some such cases will certainly be reported eventually, as they must with any dye. No direct comparison was made with other drugs because it was felt that adequate work has already been done in evaluating those other drugs, and comparisons can be made from a consecutive series.

CHART 3.

Residual Dye in Intestines

		Per Cent
Number of patients	300	100
Number of patients showing residual dye	48	16
Degree of residual		
Minimal	14%	
Moderate	2%	
Dense	0.	

Interpretation

As seen in Chart 3, only 16 per cent of patients showed residual dye in the intestinal tract. But 87 per cent of these patients were considered to have small amounts of dye of minimal density. In no case was there dense dye of the type usually seen with Telepaque®, and in no instance did the amount of a residual dye interfere with the examination.

SUMMARY

ORABILEX® is the registered name of the Fougera brand of bunamiodyl. This is a new tri-iodinated compound for oral cholecystography, which meets the criteria for an excellent practical medium. Because of its good visualization which tends to be clear but not dense; because of the low ratio of side reactions, which tend to be of a mild nature; and because it infrequently leaves residual opaque shadows in the intestinal tract, it appears to be the best of such oral media yet available for everyday use. Our own experience has led us to believe that it is the best drug now available for oral cholecystography.

ADDENDUM

Since this paper was submitted, the following reports indicating the superiority of Orabilex® have appeared:

Meszaros, W. T. *et al.*: Exhibit presented at the Scientific Section of the American Medical Association, Atlantic City, June, 1959.

Bickham, C. E., Jr. *et al.*: Exhibit presented at the Scientific Section of the American Medical Association, Atlantic City, June, 1959.

Van Epps, E. F. *et al.*: Journal of the Iowa State Medical Society, p. 331 (June 1959).

Tice, G. M.: Journal of the Kansas Medical Society, LX:118 (March 1959).

Teplick, J. G. *et al.*: The American Journal of Roentgenology, 80:6 (December 1958).

Heacock, C. H. *et al.*: Memphis Medical Journal, p. 187 (May 1959).

Geffen, A.: Radiology, 72:839 (June 1959).

Arcomano, J. P. *et al.*: American Journal of Digestive Diseases, 4:466 (June 1959).

591 E. 27th Street

Protein Bound Iodine

"A significant test of thyroid activity is obtained by the determination of the amount of circulation protein bound iodine. Some of the administered iodide is converted in the thyroid and synthesized to thyroid hormone. The amount of this organically bound iodine generated in the thyroid and circulating in the blood determines whether the patient is normal, hyperthyroid or hypothyroid. Direct measurement of the amount of circulating hormone can be done by withdrawing blood 24 hours after intravenous injection of 50 microcuries of radioactive iodine. Plasma is separated from the red cells by centrifuging. Inorganic iodide is removed from the plasma sample which is then counted in a well-type detector system. The protein is then precipitated out of the plasma and is separated by centrifuging again. This precipitate contains the radioactive protein bound iodine and is again counted.

"The ratio of the activity of the protein bound precipitate to that of the whole plasma is known as the conversion ratio. Ratios of greater than 50 per cent are indications of hyperthyroidism." — John S. Laughlin, Sloan-Kettering Institute.

Nicholas A. Antonius, M.D.

John Coniaris, M.D.

Lucian G. Massarelli, M.D.

Anthony D. Crecca, M.D.

Newark

Surgical Treatment of Coronary Artery Disease*

Indications and Results

Surely one of the most dramatic developments of mid-century medicine has been new surgical technics for revascularization of the heart in coronary disease. The St. Michael's group have been among the pioneers in this exciting field of surgery.

During the past decade the management of coronary artery disease has provoked a great deal of interest, discussion and at times, no small degree of confusion. Coronary artery disease has been considered to be almost exclusively a problem for medical management. In recent years, surgical treatment has been advocated and numerous procedures introduced. The rationale for the application of operative procedures has been developed in the pathological and animal laboratory. As a result of such experiments certain definite principles have been established, defining the ultimate goal of surgery and providing a basis for the evaluation of the various operative procedures.

The success of any revascularization procedure can be demonstrated objectively by the coronary artery ligation-mortality-infarct method of Beck [1] and the Mautz-Gregg [2] backflow studies. This plan of investigation has been pursued in our own animal laboratory. We have become convinced of the validity of the basic principles underlying the surgical treatment of coronary artery disease. Beck [3] has shown that following the Beck I operation, the mortality and size of the infarct resulting from a sudden occlusion of a major artery can be significantly reduced in dogs.[4] The operation produced a significant increase in the coronary flow; and leads to an increase in the total number of intercoronary communications.

Results of animal experimentation cannot be directly translated to humans, because of the known species differences in the anatomy and pathology of the coronary arterial system, and because of the added important factor of the psyche in man. Unfortunately, in patients, the efficacy of a revascularization procedure cannot be demonstrated objectively, and therefore must be evaluated subjectively on the basis of: (a) reduction of symptoms, (b)

*This work is from the Departments of Cardiology and Thoracic Surgery, St. Michael's Hospital, Newark, N. J. The paper was read April 29, 1959 at the Annual Meeting of the Medical Society of New Jersey, Section on Cardiovascular Diseases.

ability to return to work, and (c) length of survival. Because of the wide variability and unpredictability of the course of coronary artery disease, such a method of evaluation leaves much to be desired. The lack of objective proof that the myocardium can be revascularized is probably the chief reason for the skepticism with which a considerable segment of the medical profession has viewed the surgical treatment of coronary artery disease. Final judgment on these procedures must wait upon the accumulation of a large number of cases assembled from many clinics, together with a long term controlled follow-up study.

It is desirable that the evaluation of the results of coronary artery surgery be compared with a similar series of coronary artery involvement without surgery. However, it is difficult to evaluate patients without surgery because you can never be sure how much involvement of the heart there is; and because of the variability of the disease process itself, and the emotional symptomatology that goes with it.[5]

There have been numerous attempts to establish new sources of blood to the myocardium by augmentation of natural communications. The myocardial fibers are engulfed by an elaborate capillary and arteriolar network. These vessels provide an extensive system of intercoronary channels and anastomotic communications. Protection during times of cardiac stress is dependent, in part, upon an equitable distribution of oxygenated blood throughout the myocardium. Failure of these anastomoses to function properly can result in sudden death or progressive myocardial degeneration. One of the major objectives of surgical revascularization of the heart is to promote increased utilization of existing intercoronary communications, and the development of new anastomotic channels to provide a more equitable distribution of oxygenated blood to all areas of the heart. This occurs as a natural process and thus tends to prevent localized differences in electrical potential to adjacent heart areas which would lead to ventricular fibrillation and a mechanism death.[6]

SURGICAL PROCEDURES

Various surgical procedures have been recommended for the relief of angina and to increase the blood flow through the coronary circulation.

1. *Denervation Procedures.* It has been suggested that severe anginal pain can be relieved by sympathetic ganglionectomy, alcohol injections into the thoracic ganglia, and denervation of the aortic plexus. These are only temporary procedures. Objective evidence to corroborate the reported successes is lacking.

2. *Endarterectomy.*[7] Reaming of an artery to re-establish its lumen has been recommended. Atherosclerosis is usually a widespread manifestation, implicating secondary and tertiary branches of an artery. It is rarely a localized process involving a small segment of an artery which would be amenable to such a procedure. An attempt to open up a stenosed vessel may in itself lead to occlusion of the artery. We do not feel that endarterectomy holds much promise and we do not recommend it.

3. *Cardio-pericardiopexy.*[8] This depends on the development of a chronic pericardial inflammatory reaction by applying talcum powder to the pericardium to provide intercoronary and extracoronary communications. The small caliber of the vascular anastomoses developed prevent any significant increase in the coronary circulation. Backflow studies show only slight increase in coronary backflow.

4. *Implantation of internal mammary artery.*[9] There is no acceptable evidence that implantation of the internal mammary artery into the ventricular myocardium augments the coronary circulation.

5. *Ligation of the internal mammary artery.*[10] There is no physiologic or anatomic evidence to substantiate the hope that ligation of the internal mammary artery can stimulate collateral circulation and increase the blood supply to the myocardium. We do not advocate it.

6. *Resection of atheromatous segments of coronary arteries.*[11] Resection of atheromatous segments of coronary arteries with vascular grafts is predicated on the thesis that coronary atherosclerosis tends to be segmented and

limited to a small portion of the main coronary vessels. The low incidence of patients who show this type of involvement, the high frequency of thrombosis which develops in the grafted segment, and the inherent difficulty of the operative procedure itself makes this operation impracticable.

7. *Beck I procedure.*[12] This is a gentle abrasion of the epicardium and making a light application of 5 per cent aqueous solution of trichloracetic acid to the surface of the heart between the secondary branches of the major coronary arteries. The next step consists of narrowing the coronary sinus to a diameter of 3 millimeters. A light sprinkling of powdered asbestos is placed on the surface of the heart. Fat is then sutured to cover the anterior aspect as much as possible, as a graft. This produces an increase in coronary bloodflow, and also an increase in the number of intercoronary communications. Backflow studies following this procedure have yielded an average backflow of 4.7 cubic centimeters or 47 drops of blood per minute. To date this is the most tenable procedure to be introduced for the surgical correction of coronary artery disease.

CRITERIA OF PATIENT SELECTION

IN PREVIOUS communications we have reported our experience with a number of revascularization procedures including the Beck I operation and we have established criteria for the selection of cases for coronary surgery by classifying the potential candidates according to the following categories:

1. *Asymptomatic.* Patient with a previous myocardial infarction and symptom free. Apparently collateral circulation has developed in this group to a sufficient degree to maintain adequate myocardial blood flow. Surgery is not performed in this group.

2. *Progressive.* Patients in whom development of collateral circulation has not kept pace with the progression of the disease. Surgery in this group is potentially dangerous because the patient has not developed sufficient collateral circulation to carry him through an operative procedure.

3. *Stabilized.* These are patients with the anginal syndrome, with or without previous overt myocardial infarction. The anginal attacks are stabilized with regard to frequency and severity. However, there is insufficient coronary blood flow to maintain adequate circulation for the demands of ordinary living. This is the group for whom surgery is done.

4. *Far Advanced.* Patients in this category have disease of their coronary arteries to such a degree that there is widespread myocardial fibrosis. The heart is usually enlarged and myocardial insufficiency is often present. Surgery is of little value in this group since vascularization cannot alter the irreversible myocardial changes.

In the more specific selection of cases for surgery the following must be considered:

1. *Age per se* is not a factor in the selection of cases for surgery. Physiologic age is more important than chronologic age.

2. *Sex* is not an important factor in the selection of patients for surgery

3. An *anginal syndrome* at this time, is considered a prerequisite for performance of a revascularization procedure. The angina of effort must be stabilized with respect to frequency and severity of attacks. A progressive increase in symptoms suggests advancing disease and contraindicates surgery, at least temporarily. Angina pectoris that has been static and then suddenly increases in frequency and severity is a warning sign of impending infarction. Surgery at this time is exceedingly dangerous and may prove fatal. The occurrence of status anginosus, however, does not necessarily imply a hopeless prognosis because many cases improve with proper medical management and may then be included in the stabilized group. Status anginosus which does not respond to medical treatment warrants a grave prognosis and contraindicates surgery. The determining factors in the selection of cases for surgery are the frequency and severity of anginal attacks, and the degree of incapacitation.

Failure to obtain relief from angina decubitus following medical therapy indicates severe coronary artery disease or impending infarction and surgery should not be advised.

4. Following a *coronary occlusion,* surgery is deferred for at least six months. During

this period the development of an adequate anastomotic circulation may have developed and surgery may not be necessary. It is important to assess the degree of myocardial damage following a *myocardial infarction* before surgical procedure is attempted.

5. Mild or moderate *hypertension* without evidence of involvement of other vital organs does not contraindicate surgery.

6. The onset of *congestive heart failure,* even if under control by medical management, indicates advanced irreversible changes of the myocardium and is an absolute contraindication to surgery.

7. Surgery is hazardous in the presence of *arrhythmia,* since the arrhythmia is usually associated with extensive myocardial damage.

8. *Diabetes,* by itself, is not a contraindication to surgery.

9. *Obese* patients withstand surgery poorly. A weight reduction regimen should be instituted before surgery is undertaken.

10. Care must be taken to exclude from consideration those patients who have *psychoneurotic* symptoms simulating angina pectoris. On the other hand, in true angina pectoris, psychic factors play an important role. If an emotional disorder is present and adequate psychotherapy is instituted, the patient may improve to such an extent that operation may prove unnecessary; or the status of his anginal syndrome may stabilize, permitting surgery to be done. Patients with angina pectoris who have a psychic disorder which is not treated pre-operatively may show no improvement after surgery. In the ordinary case, the cardiologist should be able to evaluate properly the emotional stability of his patient. In more complex cases, the aid of a psychiatric consultant may be required. Preferably, the psychiatrist should be one who has had some training in cardiology.

Although we advise the operation confidently when it is indicated, we do not insist upon surgery in a reluctant patient.

ASSOCIATED CONDITIONS

ASSOCIATED serious medical disorders such as: advanced generalized arteriosclerosis, renal insufficiency, severe liver disease or chronic cor pulmonale obviously contraindicate cardiac surgery.

The above criteria apply in a general way to all revascularization procedures. However, they may be modified to meet the requirement of each individual case.

RESULTS OF SURGERY

WE HAVE in the past eight years continuously followed an original group of 32 patients who underwent the Beck operation for coronary artery disease. This group was especially selected for this study and was personally followed by us over an eight-year period. All but one of these 32 patients had previously documented myocardial infarctions. One patient had definite angina with electrocardiographic findings of myocardial ischemia. All 32 were totally incapacitated and unemployable prior to surgery. Our operative and five-year follow-up [13] results have been reported in detail elsewhere [14] and are herewith summarized with an additional eight-year follow-up of this group.

Operative mortality. There were three operative deaths among the 32 patients, giving an operative mortality of 9.4 per cent. Two of the deaths were in the younger age group and were among the first six patients subjected to surgery. One patient died of cardiac arrest at the conclusion of the first stage of the Beck II operation. The second patient had a "blow-out" of the aorticosinus graft on the thirteenth postoperative day. This was the only patient who received anticoagulants postoperatively. The third patient died of cardiac arrest during a combined Beck I and Vineberg operation. Left bundle branch block preceded the appearance of cardiac standstill and appeared as the internal mammary artery was being implanted into the ventricular myocardium. In the light of our present concepts this patient would not now be considered a candidate for surgery since he had evidence of generalized arteriosclerosis, congestive failure and marked cardiac enlargement. There were no deaths among the 29 patients undergoing the Beck I operation.

Five-year follow-up. Of the 29 patients with

the Beck I operation who were followed up to five years postoperatively, 24 (that is, 83 per cent) had excellent results. They were completely free of angina and have been able to return to their former occupations. In one of the remaining cases, the patient continued to have angina, but of much less frequency and severity than before the operation. He has been able to return to work on a part-time basis. There were two "fair" results. These occurred in patients who had an omentopexy operation in addition to the Beck I operation. Two patients had a poor result. One died eighteen months after a Vineberg operation. The other had repeated angina and several episodes of myocardial infarction and was unable to resume his former occupation.

FIVE-YEAR FOLLOW-UP OF 29 PATIENTS SUBJECTED TO THE BECK I OPERATION

Excellent result (No angina)	24(82.7%)
Good result (Infrequent angina)	1(3.5%)
Fair result (Angina of effort)	2(7.0%)
Poor result*	2(7.0%)
Full employment	24(82.7%)
Part-time employment	1(3.5%)

Mortality:	
5 years	1 (3.5%)
8 years	5 (17.2%)

*Omentopexy in addition to Beck I operation.

Eight-year follow-up. An 8-year follow-up shows that of the 28 patients who were still alive after five years, 20 (or 69 per cent) still have an excellent result. All twenty are fully employed and are completely free of angina.

EIGHT-YEAR FOLLOW-UP OF 29 PATIENTS SUBJECTED TO THE BECK I OPERATION

Excellent result (No angina)	20(69.0%)
Good result (Infrequent angina)	3(10.4%)
Poor result	1(3.5%)
Deceased	5(17.2%)
Full employment	20(69.0%)
Part-time employment	3(10.4%)

Mortality:	
5 years	1 (3.5%)
8 years	5 (17.2%)

Three (or 10½ per cent) are working on a limited basis. Five patients have died, giving an overall eight-year mortality of 17.2 per cent.

DISCUSSION

Weiss and Weiss[15] reported a five-year follow-up of 431 previously healthy men who returned to work following a myocardial infarction. Thirty-three per cent had ceased work at the end of five years and twenty-two per cent had died. In our series patients who preoperatively were considered to be totally disabled, our five year mortality was 3.5 per cent and our eight-year mortality was only 17.2 per cent. It would appear then that patients subjected to surgery have done better than would be expected in the normal progression of coronary artery disease and the anticipated mortality of a comparable period.

Approximately 90 per cent of deaths due to coronary artery disease result from ventricular arrhythmias. The ventricular extra systoles and other arrhythmias arise in adjacent areas where there is an unequal oxygenation of the myocardium. This situation leads to ventricular fibrillation and death. Protection against the prevention of this mechanism death is dependent upon an equitable distribution of oxygenated blood to the entire myocardium. An important mechanism of protection is an adequate anastomosis of intercoronary communications. One of the major objectives of surgery in coronary artery disease is to promote an increased utilization of existing intercoronary communications and to attempt to stimulate the development of new anastomotic channels.

Revascularization procedures do not alter the progression of coronary artery disease. Patients in whom the arteriosclerotic process has reached the stage of irreversible myocardial changes or in whom the progress of the disease process proceeds so rapidly that the revascularization cannot keep pace with it, will not be benefited by surgery.

The operative mortality of surgical revascularization of the heart is extremely low when one considers the nature of the disease process itself. The mortality for the Beck I op-

eration (if our criteria are met in selecting the patient to be subjected to surgery) should be low. Our operative mortality was 9.4 per cent, but this was in the early days of this procedure when we included for surgery patients who would today be considered inoperable. This is borne out by the fact that we had no operative deaths in the last 26 consecutive patients who had the Beck operation in this series.

Results of surgery in this series of patients have been most gratifying. In eight years of postoperative follow-up there have been only five long-term deaths. Of the surviving patients, 69 per cent have been completely relieved of angina and have been able to continue their former occupations. Three of the patients in this series are working on a restricted basis. Only two patients have had a poor result.

Greater emphasis should be placed on the *principles* of coronary artery surgery rather than upon individual surgical *technics*. Any operation designed to revascularize the heart should be tested in the animal laboratory before being applied to the human being. The ideal treatment for coronary artery disease is prevention of atherosclerosis and as a stopgap measure the Beck I operation [16] in our experience meets all the requirements of revascularization. Clinical experience indicates that this operation permits a rather wide latitude of application. The operative mortality is low and the results of surgery have been favorable. Combined procedures are not recommended for routine use.

SUMMARY AND CONCLUSIONS

1. Revascularization of the heart in the presence of coronary disease is a feasible procedure.

2. The validity of this premise has been demonstrated in the experimental laboratory and in human subjects subjected to surgery.

3. The indications and contraindications for revascularization procedures have been presented.

4. The results of the surgical treatment (Beck I) of coronary artery disease in thirty-two cases together with an operative mortality, short term follow-up, five and eight-year follow-up have been presented.

The authors are indebted to the New Jersey State Department of Health for assistance in various phases of this study.

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Bibliography will appear in authors' reprints.

The Surgical Conscience

Conscience in surgery means a strong sense of right and wrong, a willingness to help others, a feeling of compassion, self-discipline, and a strong faith in the sanctity of God and man. It can be conditioned by education and experience. It depends not only on the surgeon's individual moral fiber and religious concepts, but also on his heritage of philosophical doctrines, his scientific and factual knowledge, and his judgment. It determines his conduct in many situations, such as the current difficulty with hospital-acquired infections, where temporary individual gains from the misuse of antibiotics may result in protracted trouble to a community. It compels the surgeon at times to resist popular demands and to have the moral courage to protest. It requires him to rise above the selfishness of small professional groups and to devote himself to the individual patient with gentleness, compassion, firmness, and resolution. Many of the current problems concerning the care of the sick are complicated, not solved, by rigid regulations and dictatorial authority. Their solution depends, rather on a rebirth of the surgical conscience.

—Altemeier, W. A.: Arch. Surg., 79:167 (August) 1959.

Albert B. Sarewitz, M.D.

R. Wendell Ward, M.D.

South Orange

Anomalous Return of the Pulmonary Veins*

When a patient has an atrial septal defect, the doctor should consider the possibility of anomalous drainage. Though rare, the authors report a 4 per cent incidence.

Modern diagnostic procedures have made possible the identification of many surgically correctible congenital abnormalities of the heart and great vessels. One which has assumed an increasingly important position has been anomalous return of the pulmonary veins. Prior to 1949, this condition was diagnosed only at the autopsy table. In that year, Dotter *et al.*,[1] using angiocardiography and cardiac catheterization made the diagnosis in two living patients.

Appreciation of the significance of anomalous drainage came with the paper of Brody[2] in 1942. He collected a hundred cases dating back to 1739 and provided a classification of this condition. Healey[3] in 1952 reported five cases in a series of 800 autopsies. In Maude Abbott's analysis[4] of a thousand cases of congenital cardiac disease, anomalies of the pulmonary veins were present in 6 per cent. Johnson[5] reported an incidence of 9 per cent in a hundred cardiac catheterizations. In our laboratory, in seventy-five patients suspected of having congenital lesions, cardiac catheterization demonstrated anomalous pulmonary venous drainage in 3 cases, or 4 per cent.

In about 40 per cent of the reported cases, total anomalous drainage of the pulmonary veins was present. Most commonly these veins drain into a persistent left superior vena cava. Total drainage is usually characterized by cyanosis, clubbing, repeated pulmonary infections, increasingly severe right-sided heart failure and early death. A large atrial septal defect may allow a rare patient to survive infancy and even occasionally into adulthood.

In the remaining 60 per cent of reported cases, partial anomalous drainage was found. The right pulmonary veins are involved twice as frequently as the left, and most commonly enter the superior vena cava. An associated atrial septal defect is present in about 15 per cent. There is a high incidence of pulmonary hypogenesis or agenesis on the affected side. While most writers state that in uncomplicated partial anomalous drainage the life expectancy is normal, Nadas[6] points out that no accurate statistics are available but that approximately one-third of these patients die before the age of 40. It is thus obvious that it is necessary to identify the presence of this lesion so that

*From the Heart Unit and Department of Medicine, Hospital Center at Orange, Orange, New Jersey. This project was supported in part by grants from the Essex County Heart Association and the New Jersey Department of Health, Division of Chronic Illness Control.

1. Dotter, C. T., Hardisty, N. M. and Steinberg, I.: Am. J. M. Sc., 218:31 (1949).

2. Brody, H.: Arch. Path., 33:221 (1942).

3. Healey, J. E.: J. Thoracic Surg., 23:433 (1952).

4. Abbott, M. E.: *Atlas of Congenital Cardiac Disease*. N. Y., American Heart Association (1936).

5. Johnson, R. F.: Ann. of Int. Med., 42:11 (1955).

6. Nadas, A. S.: *Pediatric Cardiology*. Saunders, Phila. (1957).

surgical correction may be offered should the patient develop cardiac failure.

It is frequently impossible to make a clinical differentiation between atrial septal defect and anomalous pulmonary venous drainage without extensive laboratory investigation.

This problem is illustrated by the following case report.

A housewife was first seen by us in March 1956 at the age of 32. She had a heart murmur shortly after birth but was asymptomatic until the age of 16, at which time the diagnosis was acute rheumatic fever. Six months of bed rest were advised. Other than slight exertional dyspnea she has had no cardiorespiratory symptoms since that time.

She was a stocky well-nourished woman, five feet tall and in no distress. The lungs were clear. The cardiac rhythm was normal. The heart was enlarged to two centimeters beyond the left midclavicular line in the fifth intercostal space. A systolic thrill was palpable just to the left of the sternum in the first intercostal space. The pulmonary second sound was greatly accentuated. A harsh Grade IV systolic murmur was widely heard over the precordium and anterior chest, maximally in the second intercostal space just to the left of the sternum. A Grade III diastolic murmur was present along the left sternal border. All pulses were palpable. There was no cyanosis and the remainder of the physical examination was normal. The blood pressure was 160/90, the pulse 80 and the respirations 18.

Fluoroscopic examination of the heart showed left and right ventricular enlargement. The left atrium was not enlarged. The pulmonary artery was greatly dilated and pulsated vigorously. There was no hilar dance. Chest x-ray showed marked engorgement of the pulmonary vasculature. The cardiac silhouette was enlarged, measuring 14.6 centimeters in its transverse diameter. There was a striking prominence of the pulmonary artery segment. There were no other roentgenographic abnormalities.

The electrocardiogram showed a normal sinus rhythm at a rate of 86 and the pattern of an incomplete right bundle branch block.

The hematocrit was 39 per cent, the white blood count 3900 and the sedimentation rate 16 mm./hr. (Wintrobe). Urinalysis was normal.

On May 12, 1956 right heart catheterization was done at the Hospital Center at Orange. The catheter was passed with ease from the superior vena cava into all three of the pulmonary veins draining the right lung. Pressure measurements showed a low pressure curve in these vessels. The oxygen saturation in these vessels was 100 per cent. The remainder of the study showed slight elevation of the right ventricular and pulmonary artery pressures. Calculations showed that 60 per cent of the right ventricular output passed through the left lung, the remainder through the right. No other abnormality was demonstrated.

In 1957 the patient became pregnant and delivered a normal infant at term. In the immediate postpartum period, auscultation of the heart revealed murmurs thought to be consistent with a diagnosis of mitral stenosis and insufficiency.

In 1958, at the age of 35, she was re-examined. She had no cardiac symptoms. The heart size was unchanged. The second pulmonic sound was accentuated and split. A harsh Grade IV systolic murmur was maximally heard in the second left interspace just inside the midclavicular line. There were no diastolic murmurs. Fluoroscopy showed normal lung fields and moderate generalized cardiac enlargement. The pulmonary conus was prominent and there was no hilar dance.

The clinical features of atrial septal defects are frequently identical with those of anomalous pulmonary drainage as demonstrated in this case. This identity extends to the hemodynamic abnormalities of these two defects. In both instances there is a left-to-right shunt increasing right ventricular work load and pulmonary artery blood flow. If the veins from only one lung are anomalous the left-to-right shunt will not exceed 50 per cent of the total pulmonary blood flow. Since increased work increments of this magnitude are frequently well tolerated by the right ventricle this condition is compatible with normal longevity. Shunts in excess of 50 per cent of the total pulmonary blood flow indicate either total anomalous drainage or an additional intracardiac shunt.

Anomalously drained lungs have a decreased blood flow. In the presence of mitral valvular disease, however, the amount of blood recirculating through the affected lung may increase considerably. We believe that this applies to the case presented above.

The physical findings are usually those associated with an atrial septal defect. Murmurs may be absent but more commonly a systolic murmur is heard in the second and third left intercostal spaces. The murmur is often accompanied by a thrill and may be widely transmitted over the anterior chest. Pulmonic and apical diastolic murmurs are frequently heard and may make the diagnosis of associated valvular disease difficult to establish. Right ventricular hypertrophy may cause a precordial bulge. There may also be a deformity of the chest wall due to hypoplasia of the involved lung.

In total anomalous drainage the electrocardiogram is always abnormal. It may be normal in uncomplicated partial anomalous drain-

age, but P wave changes indicative of right atrial enlargement, right axis deviation, incomplete right bundle branch block or right ventricular hypertrophy may be seen.

X-ray examination of the chest is helpful. The right cardiac chambers are enlarged. The heart may be shifted to the right. The pulmonary arteries are enlarged and the lung fields are engorged. Occasionally there are characteristic roentgenographic configurations which in themselves establish the diagnosis.

Diagnosis by cardiac catheterization may be easy or difficult depending on the structure into which the anomalous veins drain. When the veins cannot be entered directly, arteriovenous fistulae or atrial septal defects must be excluded by other means, such as dye dilution curves and angiocardiography.

The oxygen saturation of the right ventricular blood equals that of the peripheral blood when the anomalous drainage is total. This fact serves to differentiate this defect from atrial septal defects and partial drainage.

Total drainage must be corrected surgically if infants with this defect are to survive. Partial anomalous drainage should be corrected only when a complicating lesion is present or there is evidence of right ventricular failure.

SUMMARY

THIS report describes a patient with partial anomalous drainage of the pulmonary veins complicated by mitral valvular disease.

Anomalous drainage is a relatively common congenital cardiac lesion. From our experience in the study of congenital heart disease in a general hospital, there is a 4 per cent incidence of this condition.

This condition should be considered in any patient presenting the clinical picture of an atrial septal defect.

102 Connett Place

Irradiation May Not Hurt Your Grandchildren

Women treated for sterility with x-ray therapy will be reassured by a 33-year study indicating that their children and grandchildren will *not* be damaged genetically as an aftermath of treatment.

Dr. Ira I. Kaplan, New York radiologist, reported that "no increase in genetic damage was found in 664 married women given 65 r to the ovaries and followed for one to 33 years. The incidence of *genetic damage to the children and grandchildren of this group is less than that in the normal population.*"

In this treated group 351 women had a total of 688 pregnancies. All were referred by gynecologists after other methods for the relief of sterility had failed.

There were 543 normal healthy living children of the 566 born to the 351 women who conceived. Twenty children died at or after birth and 3 children are alive with abnormalities.

"The 1958 report of the Office of Vital Statistics shows a fetal death rate of 17 per cent. In this series the rate is 20.6 per cent; however, these women were not deemed normal before therapy."

It has been said that irradiation tends to create sterility in offspring. This has not been evident in the author's study. At present 35 children of the original patients are married and 34 of these already have had 49 normal children, that is, grandchildren of the originally irradiated women. Forty-eight of these grandchildren are alive; one died shortly after birth.

"All these grandchildren of irradiated women are physically and mentally well," Dr. Kaplan continued. "There has been no cancer or leukemia in any of the children or grandchildren of the irradiated women over the course of the past thirty-three years. Some of these children are now past thirty years of age."

*Kaplan, Ira: *Radiology*, 72:518 (April) 1959.

THEODORE L. SAXE, M.D.

Jersey City

Fracture of the Penis

Can only bones fracture? This hard question is partly answered by this case report—which also carries, as an obiter dictum, a warning against cocktails.

PENILE injuries are uncommon in spite of the exposed anatomical position of the organ, and the forces to which it may be subjected.

Rupture of the corpus cavernosum—fracture of the penis—is in particular, an oddity. It is sometimes associated with rupture of the urethra.

On October 24, 1957, a patient called to request an immediate appointment because "an accident occurred at home causing blood and clots to come from the penis." Within the hour, he appeared at my office—apprehensive, but in no acute distress. He had driven the 20 miles from home by himself.

The apprehension, I soon learned, was not especially due to the bleeding, but more with respect to "what can I tell my wife when she comes home?"

Approximately 1½ hours previously, this 52-year old man, feeling a desire to masturbate, inserted the penis into the narrow neck of a cocktail shaker. During erection, the patient, who volunteered the information that he is moderately hard of hearing, heard a "cracking sound." The penis became limp, and blood with clots poured from the meatus. There was little or no pain. The patient took a handkerchief, tied it around the base of the penis as a tourniquet, and the bleeding slowed down to a trickle. There were no cuts or breaks in the skin. Blood clots, however, were noted in the meatus. The handkerchief tourniquet was released, clots passed from the meatus, and steady dripping of blood followed. The shaft of the penis was edematous. There was extravasation of blood along the shaft of the penis on the right side, also down into the scrotum and perineum. On admission to Christ Hospital, his temperature was 100.2. He was unable to urinate. There was moderate bilateral deafness.

Immediate cystoscopy was carried out under thiopental anesthesia. The panendoscope met mild resistance in the pendulous urethra and then passed into the bladder. Blood clots passed through the instrument, and then clear, amber urine. The bladder and posterior urethra appeared normal. In the posterior portion of the pendulous urethra, a tear in the urethral mucosa was noted on the right wall. The corpus spongiosum could be identified through this tear, and the bleeding apparently came from this area. The remaining portions of the urethra were normal. A number 24 Foley catheter was inserted into the bladder without difficulty, and constant drainage instituted.

Penicillin-streptomycin injections were given twice a day throughout the hospital stay. Chrymotrypsin,* 0.5 cubic centimeter twice a day was started on the second day of hospitalization, and continued until time of discharge. Ice packs were applied to scrotal area for 72 hours. Temperature rose to 104 by the third day, and gradually subsided to normal by the seventh day.

*This is a proteolytic enzyme, made by Armour Pharmaceuticals, tradenamed Chymar, delivering 5000 units of proteolytic activity in each cubic centimeter.

The extravasation of blood noted on admission became more pronounced within 48 hours. Discoloration spread along the shaft of the penis, the scrotum, and the perineum. Then it crept up on the abdominal wall in the suprapubic region. There was no increase in the area of discoloration after 48 hours.

The catheter was removed on the ninth day, voiding took place without difficulty, and the patient was discharged on the tenth day. A number 24 sound was passed without difficulty 3 weeks after discharge from the hospital, and again 2 months later.

The discoloration of skin due to extravasated blood disappeared within 3 weeks.

Erections and ability to have coitus are normal, according to the patient.

Creecy and Beazlie† have searched the medical literature, and reported a total of 21 cases of fracture of the penis, including one of their own. In this report, the cause was listed as follows: Striking or kneading with the hand to reduce erection—6 cases; coitus—4 cases; rolling over in bed—4 cases; bumping into chair—1 case; thrown on saddlehorn of motorcycle—1 case; striking toilet seat—1 case; kicked in fight—1 case; kicked by horse—1 case; slammed in car door—1 case.

The loud, cracking sound at the time of fracture has been a rather constant finding in the history.

Treatment has been conservative in most of the cases. Cystostomy, incision and drainage, and surgical repair of the tears, have been necessary in a few instances. Trypsin probably hastens the resolution of the ecchymosis and swelling. Normal function apparently returned in all reported cases.

†Creecy, A. A. and Beazlie, F. S.: Journal of Urology, 78:620 (1957).

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College "Drop-Outs"

The "spoon feeding" of children has been blamed for the high rate of drop-outs from college. So writes Irwin in the April 1959 *Today's Health,* published by the American Medical Association.

The root of the high drop-out rate lies in psychologic troubles. Students are not mature enough to cope with the demands of college.

They are the product of an "era of spoon feeding." When they get to college and find that everything is not done for them, they crack up.

Parents can help their children remain in college by leaving the children alone; by seeing that they have information about college and career selections, but letting them make their own choice; by refraining from imposing their parental interests on the children; by seeing that children have a previous living-away-from home experience; by not overstressing the need for high grades, and by letting the children earn part of their own expenses.

For students who want to avoid "joining the army of drop-outs," Irwin offered the following suggestions:

—Before going to college, try to get a realistic picture of what to expect.

—Recognize that college will present stiff academic competition.

—From the start, budget study time.

—If you are shy, get a roommate. Make yourself available for social contacts.

—Try to think through what you want to get out of college, then make sure your work has a direct relationship to your career.

—Get plenty of rest, and realize that minds do not work better when stimulated by anything stronger than coffee or "Coke."

—Give the college a chance to provide helpful guidance for adjustment. Know what resources the college offers and take advantage of them.

Aaron Weiner, M.D.

Fair Lawn

Occupational Bronchial Asthma*

Mechanism and Diagnosis

Many allergically predisposed individuals go through life with nothing more than an increased susceptibility to "colds." However, when exposed to low concentrations of irritants (harmless to non-allergic subjects), serious active sensitizations can be triggered. This is important in industrial and Workmen's Compensation matters.

Occupational bronchial asthma has assumed considerable importance in industry and in Workmen's Compensation hearings. I have examined and treated fifteen such cases until maximum improvement was attained. The observations here reported are based on evaluation of these cases. This included an allergic study which consisted of a detailed history, physical examination, x-ray and fluoroscopic examination of the lungs, lung function tests and laboratory examinations where indicated, intradermal tests, passive transfer tests and sniff tests when necessary.

Individuals with latent or active respiratory allergy may have irritation and injury to mucous membranes from concentration of irritants in the air at levels far below those considered unsafe for normal individuals. Brown[1] speaks of this as "non-specific aggravation." Wittich[2] calls it a "non-specific irritant acting as a trigger mechanism." Halpern and his co-workers[3] feel that local irritation or trauma, even to a mild degree, may favor the fixation of antibodies at the point of irritation. When this area is then exposed to an antigen, histamine is liberated. This liberated histamine in turn provokes the fixation of more antibody. Weaver[4] states, "As allergists, we well recognize that a slightly contaminated atmosphere which may be well tolerated by normal individuals may have devastating effects upon an asthmatic."

In reviewing our cases of occupational bronchial asthma, two mechanisms become apparent: (1) Irritation, and (2) Sensitization.

1. *Irritation*—An irritant may act as a localizing factor and precipitate or aggravate an allergic reaction in the affected organ.

2. *Direct allergic sensitization*—A patient may become sensitized to the allergen to which he is exposed.

Hansen[5] proposed a similar classification: (1) Contact chemical and contact mechanical; (2) Allergic.

An example of an irritant precipitating an allergic reaction is Case 1.

CASE ONE

A thirty-five year old male was exposed for two years to concentration of styrene much below the

*From the Barnert Memorial Hospital in Paterson. This paper was read before the Allergy Section at the Annual Meeting of The Medical Society of New Jersey in Atlantic City on April 28, 1959.

1. Brown, E. A. and Colombo, N. J.: Indus. Med. & Surg., 24:31 (1955).

2. Wittich, F. W.: Arch. Ind. Hyg. & Occup. Med., 2:329 (1950).

3. Halpern, B., Biozzi, G. and Benacerral, B.: Acta Allergologica, 8:181 (1955).

4. Weaver, M. K.: Annals of Allergy, 12:575 (1954).

5. Hansen, K.: *Occupational Allergy.* Springfield, Ill. 1958. Chas. C Thomas, p. 29.

400 parts per million considered unsafe by the American Standards Association.[6] After several months of exposure, he began having episodes of epistaxis, hoarseness, lacrimation, conjunctivitis and a productive cough. These symptoms were mild at the beginning of the week and gradually became more severe towards the end of each week. He found it necessary to go to the plant window for fresh air to obtain relief. Over the weekend, he improved. His condition became gradually worse, necessitating his transfer to another department, where there was less exposure to styrene. During vacation, his eyes cleared, his cough stopped, but the dryness of his nose and throat persisted. Further history disclosed that one year after the original onset of these symptoms, this patient became aware of a clinical sensitivity to house dust. Shortly after that, during the middle of August, there was a sudden outbreak of nasal and bronchial symptoms which persisted until the first frost. Complete intradermal testing at the initial examination had revealed marked reactions to dust and to ragweed 100 protein nitrogen units. There was no family history of allergy and no indication that this patient had ever had allergic manifestations during the ragweed season. He had become sensitized to ragweed for the first time. Presumably, the naso-bronchial irritation from styrene was the "trigger mechanism" which activated the dust and ragweed sensitization.

This patient was asymptomatic during the first few months of exposure. Subsequently, symptoms developed insidiously worse towards the end of the week. He improved over the weekend and also when he returned home in the evening. This is the typical history volunteered by such patients. During vacation, his bronchial condition cleared completely. Had he changed his job at that time, the "nonspecific aggravation" might not have occurred. After the onset of this aggravation (dust and ragweed sensitization) his condition became irreversible and "vulnerable" to new sensitizations. The obvious disability is bronchial asthma, but this patient also has a derangement of his immune mechanism. Vaughn[7] referred to this as an "unbalanced allergic state."

Several additional "trigger mechanisms" may be cited from our series of cases.

A 38-year old woman exposed to lycopodium and mica as irritants developed bronchial asthma and allergic rhinitis. Allergic study revealed sensitivity to dust and molds.

A 40-year old woman exposed to the same irritants in the same plant, acquired bronchial asthma with sensitivity to dust.

A 35-year old man exposed to chromate fumes acquired bronchial asthma due to dust, grasses and English plantain.

A 26-year old man exposed to lacquer spray became asthmatic with clinical sensitivity to dust.

An example of the second or direct allergic sensitization is that of a baker sensitized to the flour with which he works. In Case 2, the clinical history, intradermal tests and passive transfer tests clearly implicate the allergen.

CASE TWO

This 34-year old baker was first examined on February 21, 1955, at which time he gave a history of coughing and sneezing of about five years' duration, worse in winter, in the evening, at bedtime and on arising. During the three months prior to the initial examination, these symptoms had become severe. Handling rye flour would make him sneeze, cough and then wheeze. Wheat flour caused no symptoms.

His first contact with a heavy concentration of rye flour was in 1950 when he started making a dough called "sauer." Making this mixture or sweeping the floor caused sneezing, coughing and then wheezing. From 1950 to 1955, this condition progressed slowly. During vacation at the seashore, in 1953 and 1954, he was entirely asymptomatic.

Intradermal skin tests for the inhalants revealed positive reactions to house dust, timothy, English plantain, tobacco and some of the molds. An autogenous extract of the sweepings of the bakery was made and tested intradermally with the following findings:

Aut. dust 1-1000—Moderate reaction
Aut. dust 1-100—Marked reaction
Aut. dust 1-10—Marked active reaction

On passive transfer tests marked reactions were obtained with house dust and autogenous baker's dust 1 to 10. An intradermal test with an extract of rye flour, gave a marked reaction, the largest I had ever seen.

On May 19, 1955, treatment with house dust, a stock vaccine, a mold mixture and the autogenous dust was started. He continued working during this treatment which lasted until September 22, 1955. During this time, he had more frequent and more severe episodes of asthma, which lasted longer than before. During the latter part of this course of treatment, he had severe attacks of asthma for a day or two after each treatment. The dose of the autogenous bakery dust was markedly reduced at subsequent treatments, but the asthmatic reactions after the treatment persisted. Desensitization was therefore halted and the patient was

6. Wilson, R. H.: Industrial Medicine, 17:199 (1948).

7. Vaughn, W. T. and Black, J. H.: *Practice of Allergy*. Mosby Co., 1954, St. Louis.

urged to stop working in the bakery. However, he continued working in that bakery until November 1957, and his condition deteriorated. Prednisone and corticosteroids were frequently administered. On March 28, 1957, he had an episode of extreme dypsnea with pain and tightness in the chest. Physical examination and x-ray revealed subcutaneous emphysema of the chest wall and neck. This followed many months of severe asthma. Finally, on November 8, 1957, because of the extreme severity of his condition, he was forced to leave his employment.

Spontaneous improvement did not occur after several months of observation. Consequently, the same treatment regime as before was started on January 13, 1958, and has been continued up to the present time. There has been some improvement. He is now clinically sensitive to house dust and molds, but his asthma can be "triggered" by fatigue, changes of temperature, humidity, tobacco and alcoholic drinks.

The following findings support the diagnosis of bronchial asthma due to inhalation of rye flour. First the *clinical* evidence:

1. Appearance of symptoms when exposure to rye flour increased.
2. Severe nasal and bronchial symptoms while handling rye flour and sweeping the floor.
3. Exacerbation of symptoms at night because of concomitant house dust sensitization. This has been observed by Brown [1] in his cases.
4. Disappearance of symptoms during vacation in early phase of illness. No improvement on withdrawal from the environment when condition was severe (mold and house dust sensitization).

There is also the following *immunologic* evidence:

1. Positive intradermal and passive transfer tests to rye flour and autogenous bakery sweepings.
2. Constitutional reactions following injections of these extracts for treatment.
3. Improvement following desensitization after patient's withdrawal from the original allergen (rye flour).

The history and clinical course of a case of occupational asthma may clearly demonstrate the etiology, but immunologic proof of sensitization is not always obtainable. Case 3 illustrates this point:

CASE THREE

A thirty-five-year old owner of a sawmill was first examined on December 12, 1952. He had had nasal and bronchial symptoms for the previous month. When he entered his sawmill, his symptoms became worse. When he approached the area where wood was being sawed, he started coughing and wheezing and had to leave the shop within a few minutes. At home, in the evening, he felt somewhat improved and during weekends he gradually improved.

Intradermal skin tests for the inhalants were essentially negative except for a moderate reaction to house dust which was not clinically significant.

Since the sawdust etiology was apparent, I obtained an adequate sampling of the sawdust in his sawmill, and from this, an autogenous extract was made. Dilutions of 1 to 100 and 1 to 10 were administered in a scheduled series of injections by a registered nurse. When higher dosages were attained, in the 1 to 10 strength, he began to have stuffiness and wheeziness a few hours after each injection, lasting for about a day. The last injection gave him a severe attack of asthma two hours later, and this had to be treated energetically with bronchodilators. At this point, treatment with sawdust was stopped.

During March 1953, he went on vacation to Florida. When he returned, he was entirely asymptomatic. On his first day back to work, he exposed himself, in my presence, to the sawings of one wood at a time, in order to note which one gave him symptoms. Since we suspected pine as the possible cause, we left that for the last. There were no nasal or bronchial symptoms when he cut fir on the milling machine, and then a few minutes later, when he cut some cypress. A few minutes, however, after starting to cut pine, his nose became stuffy and he sneezed a few times. After five minutes of this heavy exposure, he began wheezing and had to be relieved with an injection of epinephrine. At this time, an extract of pine, from the sawings in his plant was made. Intradermal tests with this pine extract were negative. Passive transfer tests with autogenous general sawdust extract were negative.

During this period, this patient's neighbor had built knotty pine walls in his cellar. Upon walking into this room, his chest became "tight" and he had to leave in a few minutes.

During August 1953, I began treating him with house dust, a respiratory vaccine and a mixture of high dilutions of the two autogenous sawdust extracts. Again, on arriving at the 1 to 10 dilution, there was no skin reaction at the site of the sawdust extract injection, but on two occasions, this patient had attacks of wheezing about two hours after the injection.

At this point, it became very apparent that total avoidance was the only course to be followed. Although he has avoided pine very carefully, up to the present time, he does have nasal and bronchial symptoms every winter, which are not severe enough, in his opinion, to require desensitization treatment.

Both clinical and immunologic findings indicate that this patient's bronchial asthma was due to pine sawdust. The *clinical* evidence includes:

1. Actual exposure to the sawing of all woods in the milling room resulted in an attack of asthma from the pine sawdust only.

2. Production of asthma when he entered the shop, was more severe and more rapidly produced in the milling room.

3. Marked improvement when away from the mill.

The *immunologic* evidence is that there was induction of asthma following increasing dosage of autogenous sawdust extract during the two courses of desensitization.

Either a latent or active allergic state is the necessary substrate for the "trigger mechanism" to operate. A characteristic clinical course, in a patient with this substrate, will provide enough evidence to make an etiologic diagnosis. In industries in which the incidence of bronchial asthma is higher than in the general population, a causal relationship between disease and occupation is recognized. Biostatistical evidence of this kind provides additional confirmation.[8]

The obvious corrollary to this is that individuals with latent or active allergy should not be permitted to work as bakers, millers, cotton strippers, or in any industry where the incidence of asthma is higher than one per cent.

It becomes apparent, at this point, that a detailed history is of prime importance in establishing a specific diagnosis. All other procedures (skin tests, passive transfer tests, sniff tests and so forth) merely serve to corroborate the clinical history. This is equally true in non-occupational bronchial asthma. Of utmost importance in our cases, is the patient and the meticulous environmental investigation by the allergist in association with the industrial physician and the industrial chemist.

SUMMARY

1. Occupational bronchial asthma is commonly caused by the following mechanisms:

(A) *Irritation,* acting as a localizing factor to precipitate or aggravate an allergic reaction in the affected organ or by

(B) Direct allergic *sensitization,* where the patient becomes allergic to the substance to which he is exposed.

2. Case reports illustrating these mechanisms are given.

3. Diagnostic procedures are described in each case and carefully evaluated.

8. Schepers, G. W. H.: Industrial Med. and Surg., 24:53 (1955).

22-32 Radburn Road

Notes on Gout

John Talbott* summarizes a discussion of gout:

Each gouty patient is an individual who may manifest one of the several clinical features of gout beginning with the mild form of the malady with no permanent stigma of the disease and progressing through the several stages of severity to chronic tophaceous gout and chronic deforming changes. Irrespective of severity, response to colchicine in the treatment of acute attacks is of diagnostic as well as therapeutic value. The response to the prophylactic regimen of colchicine and probenecid is thoroughly satisfactory.

In addition to taking the prophylactic drugs, most patients are able to enjoy a balanced diet, pursue a gainful occupation and lead an essentially normal life. Gout is one of the most satisfactory types of joint disease to treat.

* Talbott, J. H.: Lippincott's *Medical Science,* 6:21, July, 1959.

Charles F. Post, M.D.

E. William Jewell, M.D.

Ridgewood

Focal Infection in Dermatology*

Thirty years ago, focal infection was fashionable. A decade thereafter it was considered only a passing fancy. Ten years ago, medical students stopped reading about it. Is focal infection now making a come-back?

Twenty years ago the concept of focal infection as a cause of disease received a near fatal blow when Cecil,[1] formerly a staunch supporter and researcher in the field, said, "Many of us who originally accepted the theory of focal infection with enthusiasm have watched with interest and some trepidation its rapid development in the various fields of medicine; but we are now wondering if the time has not arrived for a re-evaluation of the whole theory. Many thoughtful students today question seriously its validity, and some are quite willing to throw it completely overboard. This is particularly true in Europe where the idea of focal infection has never met with enthusiastic acceptance. But even in America, the home of focal infection, scientific men are becoming a little wearied of the universal acceptance of a theory as though it were an established fact." Of course Dr. Cecil was primarily concerned with the cause and treatment of rheumatoid arthritis and it is not our purpose to engage in any controversial subject outside the field of dermatology.

The June 1950 issue of the American Dental Association Journal was devoted to an evaluation of dental foci of infection. Very little sound clinical or bacteriologic evidence could be uncovered to support the idea.[2] Acceptance of metastatic heart valve lesions caused by Streptococcus viridans following dental extractions in cases of old rheumatic fever going on to subacute bacterial endocarditis was the sole survivor of a once broad concept. It is readily apparent that many excesses were committed when wholesale removal of sound teeth and tonsils was performed in vain attempts to treat a variety of ill-defined syndromes and diseases of unknown etiology.

For focal infection, then, the road back has been a long one. For one thing, most clinical studies on the subject lend themselves poorly to statistical analysis. Then, too, corroborative bacteriologic and immunologic evidence is usually lacking. While no one questions the existence of tuberculids, syphilids and dermatophytids, the importance of focal infection in other dermatologic diseases of more complex etiology is difficult to evaluate.

Four possible mechanisms of focal infection were advanced in a 1954 article by Nelson.[3] These are as follows:

*Presented at The Medical Society of New Jersey's Annual Meeting, Dermatology Section, April 28, 1959.

1. Cecil, R. L. and Angevine, D. M.: Clinical and Experimental Observations on Focal Infection with an Analysis of 200 Cases of Rheumatoid Arthritis. Ann. Int. Med., 12:577 (Nov. 1938).

2. Easlick, K. A. *et al.*: An Evaluation of the Effect of Dental Foci of Infection on Health. J. Amer. Dent. Assn., 42:615 (June 1950).

3. Nelson, C. T.: Focal Infection and Diseases of the Skin. Postgraduate Med., 15:557 (June 1954).

1. The metastatic mode of spread of infection as seen in bacterial endocarditis;

2. The dermatophytid-tuberculid mechanism in which nitrogenous products of microbial metabolism reach previously sensitized tissues and set up distant tissue reactions;

3. The important Shwartzman-like reaction in which the micro-organisms present in the focus need not resemble a previous infection at the reaction site; and, finally,

4. Antigen formation by the interaction of bacteria and body tissues in which antibody formation occurs . . . "in the host against his own altered tissue components." Nelson[3] concludes that in dermatologic conditions the reaction is commonly . . . "the result of an allergic response of sensitized tissue to the various microbial products released from the focus."

Our interest in this problem began about ten years ago when one of us (C.F.P.) was associated with today's distinguished guest speaker. Dr. Andrews[4] is a pioneer in this field and his concept of the pustular bacterid has withstood the test of time and is continually gaining wider acceptance.[5] In 1948, Andrews, Hopper and Domonkos[6] published an article on the importance of teeth in skin disease. This was followed by a study[7] on acne in which we stated the value of chemotherapeutic and antibiotic treatment and the importance of a focal infection survey in severe, persistent, pustular acne.

Without denying the undoubted importance of focal infection in some cases of eczema, erythema multiforme and erythema nodosum, our interest has centered on pustular acne, urticaria, pustular bacterid and rosacea in the present study.

ACNE VULGARIS

THE records of 1153 patients with all types of acne were reviewed. It was found that 217 patients with pustular acne, in whom no foci of infection could be demonstrated, were treated with systemic sulfonamides or antibiotics. The duration of continuous therapy varied from two to three weeks to as long as two years. Our results were similar to many other reported series, namely, 85 to 90 per cent improved or clear and 10 to 15 per cent failures.

Of the total of 1153 acne patients 116 (about 10 per cent) had focal infections. All of these cases of acne were of the pustular type and 20 per cent had cystic lesions as well. There were 79 females and 37 males. A predominant number of cases were over 18 years old (age range 12 to 38). Ninety-four patients had foci of infection surgically removed and were followed sufficiently to assess their results. The sources of the focal infections and the results are shown in Tables 1 and 2.

TABLE 1.

SOURCES OF FOCAL INFECTION IN 94 CASES OF PUSTULAR AND CYSTIC ACNE VULGARIS

Teeth	77 (81.9%)
Tonsils	12 (12.7%)
Teeth and tonsils	3 (3.2%)
Teeth and pilonidal cyst	1 (1.1%)
Teeth and hidradinitis suppurativa	1 (1.1%)
Total	94 (100.0%)

TABLE 2.

RESULTS OF REMOVAL OF FOCAL INFECTIONS IN PUSTULAR AND CYSTIC ACNE VULGARIS

Clear	31 (33.0%)
Improved	50 (53.2%)
Not improved	13 (13.8%)
Total	94 (100.0%)

It may be stated in general, that the search for, and removal of, bonafide focal infections in pustular acne patients will result in the same overall results that routine treatment will bring about in the average, uncomplicated case.

You should consider possible focal infection in:

4. Andrews, G. C.: Diseases of the Skin, 4th Edition. W. B. Saunders Co., Philadelphia (1954).

5. Andrews, G. C. and Machacek, G. F.: Pustular Bacterids of the Hands and Feet. Arch. Dermat. and Syph., 32:837 (Dec. 1935).

6. Andrews, G. C., Domonkos, A. N. and Hopper, M. E.: Teeth and Skin Diseases. N. Y. State J. of Med., 48:2029 (Sept. 15, 1948).

7. Andrews, G. C., Domonkos, A. N. and Post, C. F.: Treatment of Acne Vulgaris. J.A.M.A., 146:1107 (July 21, 1951).

1. All patients with severe, pustular-cystic acne in any age group;
2. Pustular acne patients over 18 years old who have not responded to routine treatment;
3. Pustular acne that clears on systemic antibiotic therapy and relapses when the drug is discontinued; and
4. Pustular acne that has not responded to a complete course of fractional x-ray treatment.

URTICARIA

We reviewed 107 cases of urticaria. Of 74 in which the cause was undetermined, 25 (that is 23 per cent) were due to focal infections. The only other single cause as frequently incriminated in urticaria was penicillin allergy. Except for occasional cases of pharyngitis and gastro-enteritis, most cases of urticaria caused by focal infection will be of several weeks' or months' duration. In this series, the average duration was 10 weeks (See Tables 3 and 4).

TABLE 3.

CAUSES OF URTICARIA

Penicillin	25 (23.4%)
Focal infection	25 (23.4%)
Food	9 (8.4%)
Psychogenic	8 (7.4%)
Medication other than penicillin	4 (3.7%)
Urticaria due to cold	3 (2.8%)
Cause undetermined	33 (30.9%)
Total	107 (100.0%)

TABLE 4.

SOURCES OF FOCAL INFECTION IN 25 CASES OF URTICARIA

Teeth	16 (64.0%)
Throat infections	3 (12.0%)
Cholecystitis	2 (8.0%)
Gastro-enteritis	2 (8.0%)
Intestinal parasites	2 (8.0%)
Total	25 (100.0%)

ROSACEA

The records of 174 patients with all types of rosacea were reviewed. In the search for focal infection in the severe, pustular cases, 15 patients (8.6 per cent) with one or more abscessed teeth were found. When the sources of dental infection were improved, our results in this group of 15 patients showed that 10 cleared completely and 3 were removed in an average of four weeks. None failed to improve. Two patients were lost to follow-up.

Most cases of rosacea are not pustular to begin with and the usual case will respond to routine therapy. X-ray treatment is seldom necessary. A search for focal infection in the severe, pustular cases will be successful in a limited number of cases and these foci will be chiefly abscessed teeth. Removal of abscessed teeth in these cases should bring about prompt and pronounced improvement (See Tables 5 and 6).

TABLE 5.

SEVERE PUSTULAR ROSACEA WITH ONE OR MORE ABSCESSED TEETH

Males	4
Females	11
Age range	28 to 60 years
Average age	40 years
Duration before treatment	3 years
Duration of active treatment	3 months

TABLE 6.

RESULTS OF REMOVAL OF ABSCESSED TEETH IN SEVERE PUSTULAR ROSACEA

Clear	10 (66.6%)
Improved	3 (20.0%)
Not improved	0 (00.0%)
No follow-up	2 (13.4%)
Total	15 (100.0%)

PUSTULAR BACTERID

Twenty patients with a persistent pustular eruption of the palms and/or soles, who met the usual criteria for the diagnosis of pustular bacterids, were found to have demonstrable foci of infection. Thirteen of them were females. Average age was 41 years. (Age range from 27 to 69). See Tables 7 and 8.

TABLE 7.

SOURCES OF FOCAL INFECTION IN 20 CASES OF PUSTULAR BACTERID

Teeth	15
Tonsils	3
Teeth and tonsils	1
Pyelitis	1
Total	20

TABLE 8.

RESULTS OF REMOVAL OF FOCAL INFECTIONS IN PUSTULAR BACTERID

Clear	10
Improved	1
Refused treatment or not followed	9
Total	20

Systemic antibiotic therapy is useful as a diagnostic test only. It is unlikely that any permanent cures can be obtained through its use in the treatment of pustular bacterids.

A surprisingly large number of patients (almost half) refused to have obvious foci of infection removed. One lady with a particularly severe eruption of the hands and feet and very bad tonsils told us that she had been treated by another dermatologist for a fungus infection for seven years and she thought it was ridiculous to consider any other diagnosis. These patients are hard to convince concerning the true nature of their disease.

PUSTULAR BACTERID CASE REPORTS

Case No. 1. A 69-year old man presented himself with a pustular, scaly eruption of the palms and soles of six months' duration. Cultures and scrapings for fungi were negative. Dental x-rays revealed some thickening of the periodontal membranes but no significant evidence of infection in the mouth was seen. A complete blood count showed a leukocytosis of 15,850 with 8 per cent eosinophils. Urinalyses showed intermittent albuminuria and a sediment loaded with white blood cells.

Initial treatment with Aureomycin® and then Gantrisin® by mouth and Terra-cortril ointment® locally produced temporary clearing.

Urologic consultation showed a Grade II benign prostatic hypertrophy and a hypotonic bladder containing 900 cubic centimeters of residual urine. Small bilateral renal calculi were also present.

A suprapubic prostatectomy was done. Within four weeks, without any other therapy, the eruption of the hands and feet showed complete clearing. From time to time the patient has had a small amount of infection develop in the region where the prostate was removed. Each time his urine sediment shows some white blood cells there is a slight flare-up of the eruption on his hands.

Case No. 2. A. 41-year old man was seen for a persistent pustular dermatitis of the feet of 18 years' duration. He had received previous treatment for dermatophytosis of the feet. His previous treatment also included x-ray therapy. On the advice of another physician all of his teeth had been removed several years previously with no effect on the eruption of the feet.

Repeated scrapings and cultures for fungi were negative. Urinalysis was normal. The white blood cell count was 13,150.

Routine therapy with Burow's solution soaks, Gantrisin® by mouth and the local application of antibiotic-hydrocortisone ointment produced a temporary remission. X-rays of his jaw were negative for retained root fragments or cysts.

It was felt that chronically infected and enlarged tonsils were present. Following consultation with an otorhinolaryngologist a tonsillectomy was performed. The eruption of the feet was clear within six weeks and he has remained asymptomatic for the past four years.

Case No. 3 A 43-year old woman was seen with a severe, bilateral, pustular eruption of the palms and soles of several weeks' duration. She had a leukocytosis of 18,300 with a normal differential count. Urinalysis was negative. Four abscessed teeth were seen in her dental x-rays.

Following removal of the four abscessed teeth, there was rapid clearing of the entire eruption but a fistula developed between the extraction site of her upper left canine tooth and the maxillary sinus. Repeated exacerbations of the eruption on her hands and feet occurred until the fistula was successfully closed by means of a plastic repair. Within two months after her upper jaw healed, the eruption cleared completely and there has been no recurrence over a period of six months.

At this time we would like to stress the importance of the physician-dentist relationship in the search for focal infection in the teeth. The cooperation of the dentists with us has been excellent. After the patient has had an oral examination by the dentist and x-rays have been taken, we have made it a routine practice to examine the dental x-rays ourselves. Then, we call or write the dentist and, with his advice, a joint recommendation is made to the patient. We have been able to broaden our knowledge of oral radiographic and clinical diagnosis and to correlate dental pathology with dermatologic disease in this manner. We never give the impression that we are "checking up" on the dentist and, indeed, we are not doing so. The dentist's advice usually supersedes our own, particularly in questions of whether previously filled root canals or impacted teeth are sources of focal infection. Usually, in fact, our referral has been responsible for necessary dental work that had been neglected by the patient.

Our colleagues in rhinology and laryngology have been particularly helpful, although we

have found that the onus for help or cure rests squarely on our own shoulders. A thoughtful, orderly approach to the problem of infection in the nose or throat is usually rewarded with good clinical results when infection in the sinuses or tonsils is found and eliminated.

Cooperation of the roentgenologist, surgeon and genito-urinary specialists is important in cases of possible cholecystitis, appendicitis (none in our series), pilonidal cyst and infections of the urologic and genital tracts.

SUMMARY AND CONCLUSIONS

1. Ten to fifteen per cent of all cases of acne and rosacea and almost twenty-five per cent of urticaria cases will exhibit demonstrable foci of infection. When the diagnosis is secure, *one hundred per cent of pustular bacterids show focal infections.*

2. Focal infection cases are notoriously resistant to treatment and are usually of longer than average duration.

3. Comprehensive laboratory and x-ray studies and consultation with dentists and other medical specialists will eliminate unnecessary surgical procedures done in the name of removal of focal infections. Successful search for and elimination of foci of infection in selected dermatoses will give good clinical results. The modern theory of focal infection in dermatology will be enhanced thereby and the theory will assume its proper position in our methods of diagnosis and treatment.

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Gout and Idleness

Altschule (Mark D. Altschule, M.D. in Lippincott's *Medical Science*, 6:19, July, 1959) comments that severe restriction of purine intake fails to prevent attacks of gout, and on the other hand that total caloric intake is more important in the prevention of attacks than the amount of purine-rich food. It is unlikely that the ingestion of small or moderate amounts of purine-rich foods can have any marked effect on the course of gout.

There is a significant correlation between the blood-lactate level and uric-acid retention. Although the rise in blood lactic-acid level during exercise is excessive in many diseases, patients with these conditions would hardly be able to continue severe exercise long enough to influence their urate clearance significantly if they had gout. However, a state of good physical training in normal persons prevents large rises in blood-lactate concentration during exercise. This may, perhaps, give some support to the belief that gout is uncommon in those who do heavy labor and that it is a disease (at least according to eighteenth-century authors) of scholars and the idle rich.

Skin Diving May Be Unhealthy

An article in the August 1959 *Today's Health* says that skin diving makes demands on the body which are unlike those met in everyday life. For this reason it is unsuitable for persons with certain types of disorders.

—Navigating under water requires heavy exertion and those with respiratory problems or heart and blood vessel disease should not attempt it.

—Because of pressure changes which the skin diver will encounter, the ears and sinuses must be in good condition and able to equalize pressure.

—A perforated eardrum means that water will almost certainly enter the middle ear. Ear plugs are no help in this case since they are for surface swimming only and should not be used for diving; water pressure would cause ear pain and possible injury.

—The mental attitude of some persons can make skin diving a hazardous business. Swimmers who are reckless and think it's fun to take unnecessary chances, or those who panic in emergencies, are likely to be threats to themselves and their fellow divers.

I. J. Sobel, M.D.

Passaic

The Common Cold

Prophylaxis and Treatment with a Water-Soluble Bioflavonoid Compound. A Report of 176 Cases.

Dr. Sobel points out here the effectiveness of water-soluble citrus bioflavonoids in the treatment of the common cold without bacterial complications.

The common cold affects many millions of people each year all over the world and is the largest single cause of absenteeism in industry and commerce. For many decades, it has been a problem for the medical profession. Only recently are the nature and the implications of this disorder becoming clear. That it is of viral origin is now generally accepted. Seventy viruses discovered since 1948 have been reported causative of the common cold. Among them are two recently isolated by Chanock *et al.*,[1] which resemble, but are biologically distinct from, the influenza virus. They are referred to as Types One and Two hemadsorption virus of the myxovirus group. In spite of our recognition of the viral nature of the common cold, the intrinsic cytopathology in the common cold infection has not received wide attention.

Some years ago, Brightman[2] described the pathologic changes induced by influenza virus in man and animals. He found an inflammatory reaction in the submucosa, peribronchial lesions with congested alveolar capillaries and hemorrhages and, in general, vascular engorgement and edema of mucous membrane indicative of an injury to the capillaries. Thus it appears that in the common cold, the same pathway of viral invasion exists as has been observed in many other types of viral infections. The initial damage is to the small blood vessels, capillaries and precapillary arterioles. This facilitates the proliferation and spread of viral particles to surrounding tissue. Chamelin *et al.*[3] described, step by step, the pathway of influenza virus invasion. Forty-five minutes after virus particles were introduced into the vascular system of chick embryo, the endothelial cells of the vascular wall were invaded causing destruction of the cells and blood leakage. During the next two to four hours, the cells of the tunicas—intima, media and adventitia—were attacked by virus with multiple hemorrhagic areas becoming visible. The capillaries were partly or completely destroyed with subsequent inflammation of the extravascular tissue.

The characteristic destructive affinity of influenza virus for the capillary wall finds explanation in its enzymic activity. Recent in-

1. Chanock, R. M., Parrott, R. H., Cook, K., Andrews B. E., Bell, J. A., Reichelderfer, T., Kapikian, A. Z., and Huener, R. J.: Newly Recognized Myxoviruses From Children with Respiratory Disease. New England J. Med., Jan., 1958.

2. Brightman, I. J.: Recovery of a Filtrable Virus from Children with Influenza. Am. J. Dis. Child., 52:78, 1936.

3. Chamelin, I., Kato, Sh., and Kim, T.: Vascular Injury Caused by Influenza Virus. Medical Section, Ann. Meeting Fla. Acad. Sciences, Dec. 1956.

vestigations by Curtain and Pye,[4] Curtain *et al.*,[5] and Zilliken *et al.*[6] demonstrated that influenza virus particles act in an enzymic fashion on specific receptors, which are mainly of a mucoprotein nature, and decreased or destroyed its protective properties. As a result, the viral particles release certain enzymes like hyaluronidase, or substances like leukotaxine, both of which are known to increase capillary permeability (Menkin and Kadish).[7]

These recent biochemical findings regarding the mechanism of influenza viral invasion and resultant pathology acquire a particular interest in view of what is known about the chemistry of the capillary wall. Studies by Zweifach[8,9,10] and Danielli and Stock[11] have shown that the proper functioning of capillaries depends on the "cement substance" covering the pores of the capillary wall, which is of a mucin nature. Once the viral particles reach the capillaries of the mucous membranes of the respiratory tract, the mucin-like cement substance of the capillary wall is destroyed, the vessels are then penetrated permitting a spread of the infection. When all the known facts about the character and *in vivo* behavior of influenza virus and of the capillary wall are considered together, one may more readily understand why and how influenza virus affects the capillary system and extends its invasion.

Experimental investigations reported by Sokoloff and Redd,[12] Sokoloff *et al.*[13] and others, have indicated that the water-soluble bioflavonoids exert a protective influence against the destructive effects of bacterial polysaccharides and leukotaxine upon the mucin-like substance of the capillary wall and that some bioflavonoids provide protection against viral invasion (Cutting *et al.*).[14,15]

Menkin[16] has shown that the water-soluble bioflavonoids, without vitamin C, inhibit experimental inflammation over a wider range of pH than either cortisone or ACTH.

Numerous clinical papers have also been published on the therapeutic usefulness of bioflavonoids for the correction of increased capillary fragility as present in such conditions as little stroke, habitual abortion, erythroblastosis, retinopathies, epistaxis, periodontal disturbances, surgical trauma, and generally speaking, in the capillary syndrome.

SCOPE OF THIS REPORT

THIS is a report on our clinical experience with a bioflavonoid compound in the treatment of upper respiratory infections. During the years 1957 to 1959, we treated 176 cases of common cold with a water-soluble bioflavonoid fraction derived from citrus combined with ascorbic acid.* We also gave particular attention to the possible value of bioflavonoids as prophylactic medication for patients susceptible to frequent recurrences of respiratory infections on the assumption that maintaining the integrity of the capillary wall would increase resistance to viral infection.

4. Curtain, F. M., and Pye, J.: A Mucoprotein from Bovine Submaxilliary Glands with Restricted Inhibitory Action Against Influenza Virus Hemagglutination. Australian J. Exp. Biol. & Med. Sci., 33:315, 1955.

5. Curtain, C. C., French, E. L., and Pye, J.: Preparation and Properties of Inhibitor of Influenza Virus Hemagglutination. Australian J. Exp. Biol. & Med. Sci., 31:349, 1953.

6. Zilliken, F., Werner, G. H., Silver, R. K., and Gyorgyi, P.: Studies on the Enzymic Properties of Influenza Virus. Virology, 3:464, 1957.

7. Menkin, V., and Kadish, M. A.: Studies on Physiological Effects of Leukotaxine. Am. J. Physiol., 125:524, 1938.

8. Zweifach, B. W.: Micro-manipulative Study of Blood Capillaries. Anat. Rec., 59:83, 1934.

9. Zweifach, B. W.: Structure and Reaction of Small Blood Vessels in Amphibia. Am. J. Anat., 60:423, 1937.

10. Zweifach, B. W.: Character and Distribution of Blood Capillaries Anat. Rec., 73:4275, 1939.

11. Danielli, J. F., and Stock, A.: The Structures and Permeability of Blood Capillaries. Biol. Rev., Cambridge Phil. Soc., 19:81, 1949.

12. Sokoloff, B., and Redd, J.: Capillary Permeability and Fragility. FSC, Mono. 1 pp. 1-39, 1949.

13. Solokoff, B., Eddy, W. H., and Redd. J.: The Biological Activity of a Flavonoid (Vitamin 'P') Compound. J. Clin. Invest., 30:395, 1951.

14. Cutting, W. C., Dreishbach, R. H., Azima, M., Neff, B. J., Brown, B. J., and Wray, J.: Antiviral Chemotherapy. Flavonoids. Stanford Med. Bull., 9:236:42, 1951.

15. Cutting, W. C., Dreishbach, R. H., and Matsushima, F.: Antiviral Chemotherapy. Parenteral and Other Effects of Flavonoids. Stanford Med. Bull., 11:227, 1953.

16. Menkin, V.: Amer. J. Physiology, 196:1205, 1959.

*C.V.P. containing per capsule 100 mg. water-soluble citrus bioflavonoid compound and 100 mg of. ascorbic acid, manufactured by U. S. Vitamin and Pharmaceutical Corporation, New York, N. Y.

PROPHYLAXIS IN THE COMMON COLD

SIXTY-TWO patients were given the water-soluble citrus bioflavonoid compound as a prophylactic medication, 2 capsules daily, for a period ranging from one to two years. They were selected for study because of a past history of extreme susceptibility to common cold and influenza. Twenty-two of them did not have a single attack of common cold or influenza while on this "preventive therapy." The remaining 40 patients each had but one episode of "cold," which was very mild and subsided within two to three days.

THERAPY OF COMMON COLD

THE general treatment in a disease such as the common cold is of a palliative nature. Most regimens stress giving copious fruit juices, especially citrus juices. From time immemorial, the people of Italy and Southern France have been using lemon and orange juices as the chief, if not the only, remedy in common cold. As both lemon and orange juices are a rich source of water-soluble bioflavonoids and ascorbic acid, it appeared logical to us to treat this type of infection with a concentrated form of these two factors. A large glass of orange juice contains about 50 milligrams of water-soluble bioflavonoids and 60-75 milligrams of vitamin C. Thus, patients given 400 milligrams of bioflavonoids and 400 milligrams of ascorbic acid every four hours received, in terms of bioflavonoids and vitamin C, the equivalent of 8 large glasses of orange juice. The results of such intensive therapy were gratifying. Of the 176 cases so treated, 160 responded promptly. As a rule, a complete abatement of symptoms occurred in 24 to 72 hours in most of those cases apparently uncomplicated by bacterial involvement. In view of the great variation in the course and duration of common cold infection, one should evaluate the results of any therapy with reservation. Nevertheless, the overall response obtained from the bioflavonoid therapy in this series of 176 cases gave us a definite impression of its salutary effect.

The following case histories illustrate the beneficial effect of prophylactic and ameliorative therapy with the water-soluble citrus bioflavonoids.

CASE ONE: MALE 56

Coronary artery disease, grade III. Essential hypertension. Diabetic for 10 years. Parkinsonian syndrome. In the past, had 4 attacks of common cold or influenza per year. Diabetes controlled by diet and insulin. His blood pressure was 170/110. Blood sugar: 170. Temperature: 102. Coryza and low back pain. Oral mucous membrane inflamed and red.

Treatment: 4 capsules bioflavonoid compound* every four hours.

Results: After twenty-four hours, the temperature went down, and all symptoms subsided. Two capsules a day were recommended as a prophylactic measure. During the twelve months thereafter, had no episodes of common cold or influenza.

CASE TWO: MALE 49

Coronary disease, hypertension, obesity and diabetes of 3 years' duration. Frequent episodes of cold and influenza, up to 7 per winter. His blood pressure was 160/100. Temperature was 102. Blood sugar: 180. Diet and insulin. Acute upper respiratory involvement. Coryza, acute inflammation of pharynx marked with postnasal drip.

Treatment: 4 capsules of bioflavonoids every four hours around the clock.

Results: Twenty-four hours after, coryza was arrested, and the nasal and pharyngeal membranes had lost most of their engorgement. In two days, the nasal discharge was thickened and actually gone.

During the next 12 months, he was placed on the prophylactic dose of 2 capsules daily with only one mild episode lasting one day during which time he immediately took 4 capsules every 4 hours for 2 days and all symptoms were gone in 24 hours

CASE THREE: FEMALE 49

Essential hypertension. Menopausal anxiety syndrome. Flushes associated with frequent upper respiratory infections. Frontal sinusitis especially. Her blood pressure was 130/90. Chest clear. Acute sinusitis, frontal. Marked postnasal drip. Severe headache. Temperature: 102.6.

Treatment: 600,000 units of procaine penicil in Citrus bioflavonoid compound* 4 capsules every 4 hours continuous 24 hours. In 12 hours, temperature dropped to 99.8. Headache was completely ameliorated. Sinuses clear fluoroscopically and by transillumination.

Results: For next 16 months, with 2 capsules daily, she had only one mild episode of sinusitis which responded rapidly to 4 capsules every 4 hours with full amelioration of symptoms in 8 hours.

CASE FOUR: MALE 55

Gastro-enterocolitis of one year's duration. Frequent colds, associated with frontal sinusitis and allergic manifestations. Wheezing. He showed redness of eyes, rhinorrhea, postnasal drip, marked inflammation of uvula and pharynx.

Treatment: Antihistamines. Citrus bioflavonoid compound 2 capsules every 4 hours. Allergic manifestations relieved in 6 hours. Cold diminished in 12 hours and practically cleared in 24 hours.

Results: With one bioflavonoid capsule daily, he has had only 2 minor allergic attacks in 2 years.

CASE FIVE: MALE 52

Duodenal ulcer since 1950. Marked generalized anxiety state and myositis. "Fearful of going out in the cold." Frequent upper respiratory infections. Examination disclosed a temperature of 102, severe pains, tenderness in shoulders, lumbar paravertebral exquisite tenderness, loss of lumbar lordosis.

Treatment: Together with 10 grains of acetylsalicylic acid, 4 capsules of citrus bioflavonoid compound were given every 4 hours. Temperature was normal in 12 hours and muscle pain and tenderness gone in 24 hours.

Results: In the last 14 months, with only one capsule daily, he had one mild attack.

In virtually all patients in whom the water-soluble citrus bioflavonoid compound was administered prophylactically, there was a marked decrease in susceptibility to the common cold. Patients who previously suffered frequent episodes of viral infection, often of long duration and slow recovery, remained free or almost free from such attacks. In those instances where a patient did develop a cold, it was of such mild nature that it did not interfere with daily activities.

COMMENT

Long[17] emphasized that "there is no evidence whatsoever that any of the presently used antibiotics or sulfonamides have any antiviral effects." He and others are of the opinion that the routine use of antibiotics, or sulfa drugs, all of which produce some side effects, is an inadvisable practice. In patients with chronic disease (*e.g.*, cardiac involvement, hypertension, diabetes) it may even be hazardous. On the other hand, bioflavonoid therapy produces no side effects and, in fact, often produces an improvement in well-being.

Injury to the capillaries in viral invasion has long been recognized by pathologists and virologists. The current biochemical findings offer a rational interpretation of the mechanism of this injury. These observations offer a sound basis for the clinical use of bioflavonoids in the prevention and treatment of upper respiratory colds, and the favorable results obtained by the present clinical study.

17. *Current Therapy*, Edited by Howard S. Conn, P. 7, W. B. Saunders Company, 1958.

SUMMARY

1. One hundred and seventy-six patients with common cold were treated with a water-soluble citrus bioflavonoid compound and vitamin C*, in a dosage of 4 capsules every four hours. A total of 2.4 Grams of bioflavonoids and 2.4 Grams of vitamin C was administered in 24 hours.

2. In virtually all cases without secondary bacterial complications, there was a complete abatement of symptoms within 72 hours, usually within 24 hours.

3. In 62 cases, the bioflavonoid formula was given as prophylactic medication, 2 capsules daily for periods up to two years. There was a sharp decrease in the number of episodes of the common cold among patients with a past history of high susceptibility.

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What's in the Air?

If there's anything we take for granted it's air; free as the air the phrase goes. But air has to be taken seriously as Dr. Marin here points out.

What's in the air? Plenty, if you read the papers and watch the skies. In urban areas, smog and other forms of air contamination are a growing menace to national health. Throughout the United States, studies show a growing discharge of solids and gases into the air we breathe. In Louisville, Kentucky, a daily average of 440 tons; in Seattle, Washington, 100 tons of hydrocarbons, 80 tons of nitrogen dioxide and 4 tons of sulphur. Chicago, New York, Los Angeles and, in fact, every major city shows similar averages.

Recognition of contaminated air dates back to the Egyptian Empire. History records a number of unpleasant punishments for local offenders. Modern civilization, more humane but less direct, has been slow in awakening. In a situation packing the potential wallop of a nuclear weapon, our population has coughed, wheezed and in many cases died in the seemingly clear valleys of urban and industrial living. In 1952, the death of 4,000 people in a poison-laden London fog jarred our smoke-tinged complacency. Two years later the Congress passed the first Federal Air Pollution Act authorizing a national study by the Public Health Service.

Five years and many tax millions later, it is glaringly evident that fresh air in our country is becoming progressively scarcer. Dr. Lauren B. Hitchcock, President of the Air Pollution Foundation in California, warns that unless drastic steps are taken immediately the population of every large American city will, in a few years, be breathing dangerously polluted air. Dr. Mark Hallis, Assistant Surgeon General of the United States Public Health Service, says that the death rate from lung cancer and heart disease shows a marked increase in air contaminated areas.

Remedies already applied have only scratched the surface and pure air many soon cost our citizens as much as pure water. With air pollution and cigarette smoking both possible causes of cancer, the public is understandably confused. Whether to stop smoking or stop breathing leaves little alternative. In the meantime we can only hope that the aroma of civilization will improve.

Conceivably, smog could be combustible and eliminate us all in one gloriously pungent puff.

85 Park Street

Historical Article • • •

FRED B. ROGERS, M.D.*

Trenton

Hezekiah Stites (1726-1796): 'Regular Practitioner'

This account of Hezekiah Stites, country doctor at Cranbury and ninth president of The Medical Society of New Jersey, recalls an admirable physician who practiced medicine in history-making times.

THE name of Hezekiah Stites, a country doctor at Cranbury who became the ninth President of The Medical Society of New Jersey in 1775, is almost forgotten today. Like many physicians before and since his time, however, Dr. Stites was a valuable and respected member of his community. He participated in professional, civic and church activities in addition to the general practice of medicine. The life and work of this obscure rural practitioner during the early years of our nation are deserving of recall.

Hezekiah Stites, son of John and wife, was born at Elizabeth, N. J. in 1726. His great-great grandfather, John Stites, an early emigrant to New England, had moved south to Hempstead, Long Island, in the mid-sixteen hundreds. He is said to have lived to the remarkable age of one hundred and twenty-two years; and when over a century old, walked forty miles in one day. His grandson, William, migrated from Long Island to Elizabeth in 1668—being one of the town's first settlers. His son, John, also of Elizabeth, was the father of Dr. Hezekiah. The latter probably received his schooling and studied medicine under a local practitioner there—before settling to practice at Cranbury in Middlesex County around 1738.

Cranbury, one of the oldest towns in New Jersey, was settled in 1697 by Josiah Prickett, a butcher from Burlington, and his family. In the following year, John Harrison, of Flushing, Long Island, led a group of settlers to the vicinity of Cranberry (sic) Brook, a tributary of the Millstone River which flows through the town. Here, from 1745 to 1747, David Brainerd and his brother, John, Presbyterian missionaries from New England, labored among the Indians. David Brainerd (1718-1747) helped to establish the Indian village of Bethel near Cranbury and also ministered to the peaceful natives of Crosswicks and the Forks of the Delaware. Charles McKnight, early graduate and trustee of Princeton College and pastor of the Presbyterian Church at Cranbury, was a co-worker with John Brainerd (1720-1781) after sickness forced his brother, David, from the field. (Brainerd Lake at Cranbury today honors the name of this apostle to the Delaware Indians.)

Later, in June of 1778, just before the

*Associate Professor of Preventive Medicine, Temple University School of Medicine, Philadelphia, Pa. Dr. Rogers is also Archivist to The Medical Society of New Jersey.

Battle of Monmouth, the main body of the American Army passed through and camped briefly at Cranbury—called 'Cranberry' by General Washington in his dispatches from the place. Dr. Stites was a busy physician in the neighborhood during this eventful period.

Hezekiah Stites was forty years old when The Medical Society of New Jersey was founded in 1766. At the third meeting of this body, held at Perth Amboy on May 5, 1767, the minutes state: "Dr. Stites, well known by many members of the Society as a regular practitioner (was) elected agreeable to the Constitution of this Society." Surviving records attest that he became a loyal member and promoter of the Society's aims during the remainder of his life.

Dr. Stites served as Treasurer of the Society for two years—from November 7, 1769 to November 12, 1771. During this interval he became a member of a committee selected to petition the Colonial Legislature for a charter to incorporate the Society under the authority of the State. He also examined numerous candidates for membership in the Society in these and succeeding years.



First Presbyterian Church, Cranbury, N. J.
—Woodcut by A. Ross Pittman, M.D.

WHILE serving as Secretary of the Society, from November 8, 1774 to November 14, 1775, he wrote the minutes of three meetings—preserved in the old *Transactions*. Dr. Stites was elected President of the Society—the ninth since its founding—at its meeting at Princeton on November 14, 1775. This meeting was the last formal gathering of the Society until November 6, 1781—activities of the body being interrupted by the Revolutionary War. When the group reassembled after the war, Dr. Stites gave time and interest to its work for another decade. Minutes of the organization affirm his attendance at meetings held at Princeton, Burlington, and New Brunswick from 1783 through 1788. At a meeting on May 4, 1784, his pupil and namesake, Dr. Hezekiah Stites Woodruff, also of Cranbury, was elected to membership. Record of other preceptees of Dr. Stites is unfortunately not available today. Dr. Stites' name appeared as a member of an Act incorporating The Medical Society of New Jersey which was passed at Perth Amboy on June 2, 1790.

A prominent citizen of his community, Hezekiah Stites served in official capacity on occasion. He was named one of three Justices of the Peace for Middlesex County by the last Royal Governor, William Franklin, at the Colonial Council's meeting at Burlington on November 22, 1779. Several titles to property ownership are also on record. His home, sold to Commodore Thomas Truxtun shortly before the doctor's death in 1796, still stands in Cranbury. The naval hero, who fled from the yellow fever epidemic at Philadelphia in 1793, resided at intervals at "Cranberry Place"—as he called the property—until he traded it for another farm near Moorestown, New Jersey, in 1812. Commodore Truxtun (1755-1822), one of the first six captains appointed to the newly organized United States Navy in 1794, achieved fame as commander of the frigate *Constellation*—the venerable ship which is still afloat at Baltimore, Maryland, today.

Dr. Stites was an active member of The First Presbyterian Church of Cranbury, which

had been founded in the year 1734. Upon the erection of a new edifice on King George's Road in 1785, the doctor gave a bell for the church—the bell still in use today. Like the King of Judah, for whom he was named, Hezekiah (a Hebrew name meaning 'strength of the Lord'), put his trust in God—as did the Biblical ruler cited by the prophet Isaiah in the Old Testament.

Hezekiah Stites married Mary Predmore, daughter of John Predmore and his wife who managed the Cranbury Inn for some years. Dr. and Mrs. Stites died without issue. A flat gravestone in the north plot of the Presbyterian Churchyard at Cranbury bears the following inscription:

> "Sacred to the Memory of DOCTOR HEZEKIAH STITES and MARY his wife. Doctor Stites departed this life November the 17th, 1796, in the 70th year of his age. Mrs. Stites on the 14th of April, 1794, in the 57th year of her age."

An ancient Roman author, Pliny the Younger, in the Fifth Book of his *Letters*, expressed this sentiment: "It is a noble employment to rescue from oblivion those who deserve to be remembered." In time the lives of people such as Dr. Hezekiah Stites are too often ignored in favor of lesser persons. His fine work at Cranbury and service to The Medical Society of New Jersey, though long past, remain worthy of commemoration.

Acknowledgment. The author acknowledges the assistance of Mrs. Dorothy J. Delaney, Genealogist, and the Rev. Roger Alden Kvam, Minister of The First Presbyterian Church of Cranbury, New Jersey.

2200 Hamilton Avenue

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4. *New Jersey Archives, First Series, vol. XVIII (Journal of Governor and Council, vol. VI,* 1769-1775), p. 23, Trenton, N. J., 1890.

5. *Hezekiah Stites, M.D.:* JOURNAL of The Medical Society of New Jersey 13:428, August 1916.

Men Should Cry More

Men, the "weaker sex," may have to start crying if they want to live longer, according to Dr. James O. Bond of the Florida State Board of Health. Men are less durable than women in our modern society. "Men," says Dr. Bond, "need to learn more from women either how to avoid emotional tension, or deal with it in less damaging ways than development of coronary artery disease."

One of the ways, he suggested, is for men to cry more or find a substitute for tears.

Dr. Bond warns men that "their badge of masculinity . . . is no longer an advantage in the competition for survival in today's world. It may be a handicap due to the psychological role it forces men to play in a world that no longer accommodates that role."

—May 1959 Science News-Letter

Exercise and Vasomotor Response

Reporting in the 1959 *Circulation*, Walter Redisch (19:579) studies the effect of exercise on peripheral blood flow and muscle flow in healthy adults, older patients without demonstrable obliterative arteriosclerosis, and in patients with nongangrenous obliterative arteriosclerosis who had been subjected to sympathectomy. As might be expected, basal flows were higher in young adults than in elderly persons. Basal flows were lowest in patients with obliterative arteriosclerosis. Sympathectomized limbs had a higher basal flow than the corresponding nonsympathectomized limb. Total blood flow increased in all groups following exercise. In young adults at rest somewhat more blood goes to the muscle than to the skin; in elderly persons without vascular disease the reverse is true.

Announcements • • •

Sources of Radiation

The N. J. State Department of Health is required to register sources of radiation under recent legislation. This includes the task of registering all radiation-producing machines, including x-ray machines and high voltage rectifiers, as well as isotopes and other radiation-producing material.

You may receive a card soon from the State Health Department asking you to register your machine or material with them. Please cooperate and conform to the law by doing so. If you have any x-ray or fluoroscopic machines, electron-microscopes, radioactive material or other radiation-producing instruments or materials and if you do not receive a card from the State Health Department by the end of the year, please communicate directly with the State Commissioner of Health, Dr. Roscoe P. Kandle at the State House, Trenton 25, N. J.

Exempt from registration are machines in dead storage and electrical equipment which produces less than 0.1 millirem per hour.

For further information, write to Dr. Kandle at the address above.

Arthritis for Experienced Clinicians

From March 14 through March 18, 1960, New York University will give a course in arthritis, daily 9 a.m. to 5 p.m., Monday through Friday. This is for physicians already familiar with the fundamental data essential for understanding this group of disorders. Applicants should have had five years experience in an arthritis clinic, or its equivalent. Standard differential diagnosis and treatment will not be covered. Particularly stressed will be newer concepts of etiology, newer research technics and tools, and a detailed summary of recent advances in our basic knowledge of what underlies these disorders. For details write to Postgraduate Medical School at 550 First Avenue, New York 16, N. Y., or phone extension 82 at Oregon 9-3200.

Arthritis for General Practitioners

An intensive, *full-time*, five-day course in arthritis is announced for November 9, 1959, and again (same course) for May 16, 1960. The program runs Monday through Friday, 9 a.m. to 5 p.m. at New York University. For details, write to Postgraduate Medical School, 550 First Avenue, New York 16, N. Y., or phone extension 82 at Oregon 9-3200.

OB-GYN Board Examinations

The next examinations by the American Board of Obstetrics and Gynecology will be held on January 15, 1960. Case reports must be submitted in advance. Get further details from Dr. Robert L. Faulkner at 2105 Adelbert Road, Cleveland 6, Ohio.

USPHS Examinations

Physicians interested in a career in the Public Health Service may obtain full details from The Surgeon General, U. S. Public Health Service, Washington 25, D. C. Next examinations are on November 17, 1959. Entrance pay is $8000 a year with rapid promotion the rule. Perquisites include disability retirement, sick-leave with pay, fully-paid 30-day vacations every year, swift promotion, high professional standards, exciting and important work, draft exemption and opportunities for specialized training.

Military Surgeons Meet

November 9 is the opening day of the next convention of the Association of Military Surgeons. The meeting will be in Washington, D. C. A varied menu of professional topics has been provided. For full details, write to Association of Military Surgeons, 1726 Eye Street, N. W., Washington 6, D. C.

New N. J. Fellows of the ACS

More than a thousand surgeons were inducted in Atlantic City on October 2 as the new Fellows of the American College of Surgeons. Those receiving this distinction from New Jersey at the 1959 Convocation were:

Vincent A. Burell, Phillipsburg
Carmine D. Diorio, Paterson
M. Leonard Genova, Red Bank
John D. Gossel, West Englewood
Robert G. Greene, Montclair
E. Bruce Hallet, Morristown
William K. Harryman, Jr., Hackensack
Francis P. Henry, Trenton
Robert Kollmar, Short Hills
Philip A. LaBate, Plainfield
Samuel Lerman, Cranford
Michael T. Mahoney, Newark
Jacob B. Mandel, Jersey City
James H. Mason, IV, Atlantic City
Elmer N. Mattioli, Vineland
Paul J. Miranti, Jersey City
Ralph L. Moore, Woodbury
Robert H. Null, Plainfield
Stephen H. M. Plum, Morristown
William Rubin, New Brunswick
William R. Sillery, Alpine
Walter R. Talmage, Morristown
John Trano, Elizabeth
Philip H. Voorhees, Morristown

Emotional Problems of Children

Announcement is made of a series of seminars on the common emotional problems of children to be held in Philadelphia on alternate Wednesday afternoons. The first seminar is October 21, 1959. Colloquia will be on the first and third Wednesdays of each month thereafter. This series enjoys Category I accreditation for the AAGP. The seminars are held at the Child Guidance Clinic, 1700 Bainbridge Street in Philadelphia and inquiries should be directed to Dr. Donald C. Ross at that address.

Medical Student Prize Essay Contest

All undergraduate medical students are encouraged to submit entries to the American College of Chest Physicians at 112 East Chestnut Street, Chicago 11, Illinois. First prize is $500 and other prizes are in proportion. The subject: any phase of chest diseases—diagnosis, pathology, treatment. For details write to the College at the Chicago address. Deadline is March 31, 1960.

Patients with Malignant Carcinoid

Selected patients with malignant carcinoid will be studied and treated at the National Cancer Institute of the U. S. Public Health Service in Bethesda, Md. If you have any patient with the carcinoid syndrome, communicate with Dr. Emil Frei at the National Cancer Institute, Bethesda, Md. The phone is extension 2500 at Oliver (Washington, D. C.) 6-4000. Arrangements will be made for the reception of the patient if he or she meets the eligibility criteria for this project.

Legal Environment of Medical Science

The only conference of its kind was the Conference on the Legal Environment of Medical Science held in Chicago last May. A limited number of copies of this unique meeting are now available at $2.50 each. The report is obtained by sending your check to the National Society for Medical Research at 920 South Michigan Blvd., Chicago 5, Illinois.

Pigment in Ocular Pathology

On Monday evening, December 7, Dr. Algernon B. Reese will talk on "The Role of Pigment Epithelium in Ocular Pathology." This talk will be at the New York Academy of Medicine, Fifth Avenue at 103 Street at 8:30 p.m. This is the Schoenberg Memorial Lecture sponsored by the National Society for the Prevention of Blindness in cooperation with the New York Society for Clinical Ophthalmology. All physicians are welcome.

Veneral Disease Abstract Service

Would you like to receive abstracts of current articles, from all over the world, on venereal disease? This service is supplied *gratis* by the U. S. Department of Health, Education and Welfare. Write to Dr. William J. Brown, Communicable Disease Center, 50 Seventh Street, Northeast, Atlanta 23, Georgia, and ask to be placed on the mailing list for "Abstracts of Venereal Disease Literature."

Seton Hall Names Neurology Director

Dr. Joseph M. Foley has been named Director of Neurology at Seton Hall College of Medicine, effective September 1959. An alumnus of Holy Cross and Harvard, Dr. Foley has served as a Rockefeller Research Assistant and as an instructor at Harvard. He is a national connsultant in neurology to the U. S. Air Forces. He is secretary of the American Neurological Association. Dr. Foley is married and is the father of six children. He has also been on the faculty of the Boston University School of Medicine.

Graduate Lectures in Vineland

Practitioners in southern New Jersey now have a practical graduate course available on Sunday afternoons at the Newcomb Hospital in Vineland. The meetings start at 2 p.m. and terminate at 4 p.m. The course is acceptable for 12 credit hours, (Category I), AAGP. Sponsoring bodies are the county medical societies of southern New Jersey, the Academy of Medicine of N. J., the NJAGP and the State Health Department. The material is presented by an all-star faculty:

1959

November 8: Hematologic problems in pregnancy
November 22: Hematologic problems of the newborn
December 13: Hemorrhage due to coagulation disorders

1960

January 10: The myeloproliferative syndrome
January 24: Childhood tuberculosis
February 14: The adrenogenital syndrome

For further details write to Dr. P. A. Ruggieri at 803 Elmer Street, Vineland, N. J.

Ophthalmology Symposium in N. Y.

During February 1960 there will be a colloquium on ophthalmology at the Eye and Ear Infirmary, New York. Sessions will be held every morning starting Tuesday, February 9 and running through Wednesday, February 17. For admission cards and detailed program, write to Mrs. Tamar Weber at the Institute of Ophthalmology, 218 Second Avenue, New York 3, N. Y.

Gastro-Enterologic Meeting

Wednesday, November 4 is the date for the next session of the state Gastro-Enterologic Society. The speaker, Dr. Jesse L. Bollman, will speak on newer concepts of jaundice. The meeting will be at 8:45 p.m. at the Essex House, Lincoln Park, Newark. Dr. Bollman is with the Department of Physiology at the Mayo Clinic.

Diabetes and Lipids

Announcement is made of a colloquium on Lipid Metabolism and Diabetes to be given on Wednesday afternoon (2 to 5 p.m.) October 21. This is a project of the N. J. Diabetes Association in cooperation with the State Health Department. A galaxy of distinguished speakers has been assembled. The meeting will be on the 14th floor of the Gibraltar Building, 763 Broad Street, Newark. Those coming at 12:30 (noon) will share in a buffet luncheon kindly provided by the Prudential Insurance Company. Members of the AAGP will get three hours' credit for attendance. For further details, write to Dr. Otto Brandman at 558 Prospect St., Maplewood, N. J.

Seventh Annual Cancer Seminar

November 22 has been set as the date for the Seventh Annual Seminar of the New Jersey Division of the American Cancer Society. Meeting at the Presbyterian Hospital in Newark, 45 South Tenth Street, the program will be introduced by Dr. F. Clyde Bowers, President of The Medical Society of New Jersey. Various aspects of cancer diagnosis and cancer control will be discussed in this day-long meeting. For further details write to Mr. C. C. Hansbury, Executive Director, 621-3 Central Avenue, Newark 7, N. J.

State Activities • • •

Medical Reports to OASDI Not Confidential

Doctors are reminded by the U.S. Department of Health, Education and Welfare that their reports concerning the disability of a claimant are not necessarily confidential. The claimant, if dissatisfied with the referee's decision, may appeal to the courts. At this point the courts will want to see all the medical reports even those which were made available to the agency under pledge of confidentiality. The courts have held that *the claimant has an absolute right to see these medical reports* because, unless he sees them, he has no way of defending himself against the statement that he does not have a disability or that the disability is not covered by the law.

The Federal Bureau of OASI has advised the state agencies that when a doctor is asked to give an opinion in a disputed case he should be notified that the report may be inspected by the claimant. The consultant then has a choice of either agreeing to this condition or indicating that he will not examine the claimant.

The commonest sources of difficulty have been statements made by physicians about the motivation or character of claimants. Particularly troublesome are statements which indicate that claimants are malingerers, alcoholics, or untruthful. Doctors do best who limit their findings and conclusions, as far as possible, to objectively verifiable statements.

Special Memorandum Concerning M.D. License Plates

At the direction of the Board of Trustees, at its meeting on September 20, this special memorandum is included in this issue of THE JOURNAL for the information of all members.

In response to Dr. Bowers' letter of August 10 complaining about the decision to charge a special fee of $10.00 for M.D. plates, under date of September 17, Mr. Ned J. Parsekian, Acting Director of the Division of Motor Vehicles, declared:

I am in receipt of an opinion from the Attorney General which states in part as follows:

"I understand that pursuant to the authority of this section you have fixed a fee of $10.00 for the issuance of registration plates with a particular identifying mark or marks. Having determined upon such additional fee, you have no authority to eliminate or reduce the fee for any group of private citizens, including members of the medical profession. The legislature has failed to provide any special exception for medical doctors, nor is there any discretion vested in you by Chapter 56 of the laws of 1959 to deviate from the regular fee in favor of medical doctors or any other group who apply for registration plates of a particular identifying mark or marks."

The Division of Motor Vehicles will be in a position to issue M.D. plates to any licensed physician of the State of New Jersey upon request. A fee of $10.00 will be charged for the issuance of M.D. registration plates. The $10.00 fee is not a yearly charge but will be held for the entire life of the plate which is presently estimated at five years. I should like to advise that it will not be required to forward the $10.00 fee upon making the initial request; the Division will request payment of the fee just prior to mailing plates to those who may request same.

Supplementary List No. 1

to the

1959-60 Membership Directory

Memberships reported from June 1, 1959 through September 10, 1959

N—New
R—Reinstated

ACTIVE MEMBERS

	Name	Address	County	Practice
R	Amato, Charles P.	300 Broadway, Camden	Camden	——
R	Barrett, James W.	35 Park Ave., West Orange	Essex	Gen Surg
N	Bein, Karolina B.	230 W. Jersey St., Elizabeth	Union	——
R	Bossone, Joseph E.	255 Third Ave., Long Branch	Monmouth	Gen, Gen Surg
R	Breen, James E.	507 Walnut St., Roselle Park	Union	——
R	Brooks, Bert W.	33 Northview Ave., Upper Montclair	Essex	Indus
R	Burch, Reynold E.	102 S. 14th St., Newark	Essex	Ob, Gyn
R	Clark, John J.	630 Overton Pl., Long Branch	Monmouth	Ped
N	Cohnstein, Leonard	6 Hinchman Ave., Denville	Morris	Int Med
R	Cooperman, William	647 Market St., Newark	Essex	General
N	Dixon, Ernest M.	Medical Dept., Amer. Cyanamid Co., Bd. Brk.	Somerset	Occupa Med, Toxicology
R	Duffy, Joseph F.	387 Kinderkamack Rd., Westwood	Bergen	——
R	Epstein, George J.	839 Kearny Ave., Arlington	Essex	Oph
R	Faber, Edward	1815 Hudson Blvd., Jersey City	Hudson	General
R	Friedman, Barney M.	310 Knickerbocker Rd., Cresskill	Bergen	Int Med
R	Giannini, Francis F.	67 Maple Ave., Morristown	Morris	Psy
R	Gillerlain, Joseph A.	45 Linden Ave., Haddonfield	Camden	Gen, Proc
R	Goldsmith, Richard W.	14 W. Young St., Somerville	Somerset	——
R	Goldstein, Samuel	34 E. Main St., Mays Landing	Atlantic	General
R	Hale, Matthew J.	467 High St., Burlington	Burlington	General
R	Halsted, Harry C.	Calco Chemical Div., Bound Brook	Somerset	Occupa Med
N	Harrigan, John T., Jr.	39 Gifford Ave., Jersey City	Hudson	——
N	Hastings, James B.	Medical Arts Bldg., Princeton	Mercer	Gen Surg
R	Henderson, Alfred R.	321 Sunset Ave., Asbury Park	Monmouth	Thor Surg
R	Irvin, Robert S.	Bay Head Ave. & Union St., Manahawkin	Ocean	General
R	Katz, David	785 Pleasant Valley Way, West Orange	Essex	General
N	Kay, John H.	Benetion Motors, Denville	Morris	——
R	Kelly, Frank	915 Monmouth St., Gloucester	Camden	——
N	Kidwell, Allyn P.	56 Fieldstone Dr., Basking Ridge	Morris	Int Med
N	Koropeckyj, Natalia B.	314 York St., Jersey City	Hudson	——
R	Levinson, Robert M.	824 S. 12th St., Newark	Essex	Int Med
R	Manser, Ernest E.	321 Haddon Ave., Collingswood	Camden	Int Med
R	Mason, John T., Jr.	673 Pompton Ave., Cedar Grove	Essex	General
R	McWilliams, Charles E.	116 W. Church St., Blackwood	Camden	General
R	Miller, Charles E.	208 Main St., Hackettstown	Warren	General
R	Miller, Robert L.	317 Dewey Ave., Lakewood	Ocean	Ob, Gyn
N	Munroe, Joseelyne S.	69 Clifton Pl., Jersey City	Hudson	——
N	Oldman, Elliott S.	519 Church St., Bound Brook	Somerset	Ped
R	Petinga, Thomas J.	507 Atlantic Ave., Egg Harbor	Atlantic	General
R	Proudfoot, Perry A.	527 Walnut St., Roselle	Union	——
R	Rattene, Edward	549 Mt. Prospect Ave., Newark	Essex	General
R	Riccardelli, Emmanuel F.	1670 Hudson Blvd., Jersey City	Hudson	General

	Name	Address	County	Practice
R	Ringe, Charles L.	Blair Pl., Blairstown	Sussex	General
R	Rizzolo, Edward M.	523 Union Ave., Belleville	Essex	General
R	Robinson, Collins H.	1212 Bangs Ave., Asbury Park	Monmouth	General
R	Schillinger, Raphael	702 E. Broad St., Westfield	Union	EENT
N	Sexton, Robert E.	River Rd., Point Pleasant	Ocean	——
R	Shoemaker, Thomas E., II	The Carrier Clin., Belle Mead	Somerset	Psy
R	Smith, Myra L.	375 Tower St., (Vauxhall) Union	Union	General
R	Sokal, Ernestine	Fair Oaks, Summit	Union	Psy
R	Spinnler, Henry R.	Short St., R.F.D. No. 1, Butler	Passaic	General
R	Strenski, John	330 Fairview Ave., Riverside	Burlington	General
R	Whims, Clarenee B.	5401 Ventnor Ave., Atlantic City	Atlantic	Int Med, Rheum
R	Wilkerson, William G.	69 Clifton Pl., Jersey City	Hudson	Ob, Gyn
R	Wilson, Lawrence A.	114 N. Shore Rd., Absecon	Atlantic	Int Med
R	Winkler, M. Bernard	750 Broadway, Paterson	Bergen	Neur Surg
R	Winn, Samuel L.	1616 Pacific Ave., Atlantic City	Atlantic	General
R	Yaeger, Robert N.	234 Webster Ave., Seaside Heights	Ocean	General
R	Yuekman, Robert O.	701 Madison Ave., Elizabeth	Union	General

ASSOCIATE MEMBERS

Barct, Alexander C.	1 Borden Pl., Long Branch	Monmouth	——
Bistreff, Stanio	210 Riverside Dr., New York, N. Y.	Essex	——
Boonin, Nathaniel N.	N. J. Neuro-Psychiatric Inst., Princeton	Mercer	Child Psy
Boyer, Robert J.	950 Queen Anne Rd., Teaneck	Bergen	ENT, Maxillo Surg
Chung, Emilie V. C.	N. J. State Hosp., Marlboro	Monmouth	Gen, Psy
Cunneff, Raymond L., Jr.	87 E. Front St., Red Bank	Monmouth	Orth Surg
Dortch, Joseph	45 S. State St., Vineland	Cumberland	——
Falcone, John G.	247 Livingston Ave., New Brunswick	Middlesex	General
Glick, Farrell M.	147 Park Pl., Irvington	Essex	General
Haycock, Christine E.	153 Roseville Ave., Newark	Essex	Gen Surg
LaFranco, Vito F.	56 Franklin St., Trenton	Mercer	General
Lupini, Belardino	179 Main St., Woodbridge	Middlesex	General
McCarthy, Joseph F.	615 Beatty St., Trenton	Mercer	Gen, Anes
Miller, Irwin	525 New Brunswick Ave., Perth Amboy	Middlesex	——
Pedicini, Salvador A.	10 Peck Ave., Newark	Essex	General
Porcaro, Frank	23 Sawyer Ave., Vineland	Cumberland	Gen Surg
Reby, Morris	N. J. State Hosp., Marlboro	Monmouth	General
Uhrik, Joseph	123 Main St., Metuchen	Middlesex	General
Westerhoff, Peter D., Jr.	51 Highland Ave., Midland Park	Bergen	Otolar
Witek, Victor J.	103 E. Front St., Red Bank	Monmouth	General

Obituaries • • •

DR. ALBERT J. BLAKE

At the untimely age of 49, Dr. Albert J. Blake died of a coronary attack on August 24, 1959. Born in Paterson in 1910, Dr. Blake received his M.D. at Harvard in 1937. For four years during World War II he served in the Army, rising from Lieutenant to Major. He was active in the affairs of the Passaic County Medical Society. Dr. Blake was a general practitioner with an office in Paterson. He was affiliated with both the St. Joseph Hospital and the Barnert Hospital in that city and, at the time of his death was a Paterson school physician.

DR. BERNARD FEIN

Dr. Bernard Fein, one of Newark's longest-established pediatricians died on September 11. Dr. Fein was born in Newark in 1900 and was graduated in 1924 from the Medical School of Cornell University. He became interested in pediatries very early in general practice and by 1928 was a recognized consultant in this field. He was active in the affairs of the Babies Hospital and the Beth Israel Hospital. In medical school, he achieved Alpha Omega. Dr. Fein was a certified Diplomate of the American Board of Pediatrics. Dr. Fein suffered a stroke in 1956 and decided to move to Florida and continue his practice there. He went to Florida, recuperated from his illness and passed the State Board of Examinations in that state.

DR. ELBERT S. SHERMAN

Dr. Elbert S. Sherman, one of New Jersey's pioneer ophthalmologists, died on September 11 after a brief illness. He was graduated from the Medical School of the University of Pennsylvania in 1897. For the first 10 years after his internship he did general practice but was increasingly interested in eye, ear, nose and throat work. He began specializing in that and eventually limited himself solely to ophthalmology. He was an active member of the Board of Managers at the New Jersey Commission for the Blind. He was consultant at many hospitals throughout New Jersey and in most of the hospitals in Monmouth County. He was also Chief of the Eye Service at Newark Eye & Ear Infirmary, at the Newark Presbyterian Hospital, and at the Newark Babies Hospital. He belonged to the Essex County Medical Society, the American Academy of Ophthalmology and the American College of Surgeons. He served in World War I as a Major in the Medical Corps.

DR. JOSEPH S. VAN DYKE

Dr. Joseph S. Van Dyke, one of the grand old men of New Jersey medicine, died on September 9, 1959. Born in Cranbury, N. J., in 1875, he was graduated in 1903 from the medical school of the University of Pennsylvania. He then moved to Hackensack and thereafter served the people of Bergen County for more than half a century. He was a charter member of the Palisade Park Presbyterian Church. He was affiliated with the Englewood Hospital and for many years served as chief of staff there. He was also a school physician for Palisade Park borough.

DR. WILBUR WATTS

On August 12, 1959, Dr. Wilbur Watts died at the age of 76. A native of Burlington County, New Jersey, Dr. Watts received his M.D. degree from the University of Pennsylvania in 1907. A diplomate of the American Board of Otolaryngology, he was for some years president of the medical staff of the St. Francis Hospital in Trenton. The Burlington City High School is officially called the Wilbur Watts High School in honor of Dr. Watts. He was in the Navy medical corps in World War I and rose to the rank of naval Captain. He was active in the New Jersey Society of Surgeons and was a director of the Trenton Citizens' System. For many years, Dr. Watts was chief of otolaryngology at St. Francis Hospital and consultant to several hospitals in the Mercer-Burlington area.

Book Reviews • • •

Surgical Pathology. Lauren V. Ackerman, M.D., in collaboration with Harvey R. Butcher, Jr., M.D. St. Louis 1959. Mosby. Second edition. Pp. 1096, with 114 illustrations. ($15.00)

While publication of this volume is not necessary to maintain Dr. Ackerman's preeminent position in surgical pathology, the book will certainly not detract from his acknowledged superiority in this field. He and his collaborator are to be congratulated on this well organized publication. He is to be complimented on the dedication of the volume to Dr. Arthur Purdy Stout as "the best surgical pathologist I know." The 26 chapters in the book cover practically every phase of surgical pathology. Each chapter begins with an outline of the material to be presented and concludes with an exceptionally well selected list of accurate references.

Most of the 1114 illustrations are of excellent photographic quality. They present a rapid review of gross and histologic pathology of the subjects under discussion. The 17-page index provides ready access to the conditions explained in the text. A few spelling errors have been noted.

Those physicians interested in pathology, surgery, histologic pathology, cytology, or any of the manifold applications of surgical pathology to the study of disease processes, will find this volume, either in part or *in toto,* to be authoritative and immensely valuable material for ready reference, as well as prolonged study.

The reviewer agrees with the author, that not only surgeons but any physician who fails to display some interest in this subject will fall into that class of individuals of whom you might say that "with time his ignorance is refined, rather than his knowledge broadened."

The author is to be congratulaed on the presentation of the second volume of his informative, superbly illustrated volume.

T. K. Rathmell, M.D.

A Skeptical Psychoanalyst. By Kenneth Mark Colby, M.D. New York 1958, The Ronald Press. Pp. 145.

Dr. Colby does not offer us a textbook on analytic technic. Instead he presents an anthology of highly original sidelights on the subject. He demonstrates significant sex differences in dream content. He gives hints on how the analytic session may be facilitated instead of worrying about resistance as the more traditional analytic writer does. He turns the spotlight on the thought processes of the analyst, on interprofessional relations, on psychiatric and medical organizations and on psychiatric journals. He offers helpful hints to the therapist who wants to keep analyzing himself. He has a chapter on Isaac Newton that is pure comedy preceded by a serious thesis to account for the *deja vue* phenomenon. And his "letter to a young analyst" is a gem of wit and wisdom. All in all, a fresh breeze in an area that too readily becomes stale with self-fertilization.

Herbert Boehm, M.D.

Signs and Treatment of Acute Intoxications. By W. B. Deichman, Ph.D. and H. W. Gerarde, M.D. Springfield, Illinois 1958. C. C. Thomas. Pp 154. ($3.75)

In a conveniently small size and flexible binding, the authors present a compact compendium on toxicology. Some useful material on first aid is included. Poisons are listed alphabetically and keyed by number for swift cross reference. Chemical names are used, as well as trade names (*e.g.* Tintex or Kwell) and common names (such as battery acid or horse beans) enabling the reader to find the item promptly. In all some 387 products are listed with the symptoms and treatment simply explained. This handy reference work may some day save some one's life. This—or some book like it—should be in every doctor's bag, every first aid station and in every hospital accident room.

Ulysses M. Frank, M.D.

Surgery in World War II. Neurosurgery. Edited by J. B. Coates, Jr. and four others. Washington, D. C., 1959. Government Printing Office. Pp. 466. ($5.00)

This volume deals with head injuries. Starting with the knowledge gained through the efforts of a handful of neurosurgeons during World War I (notably the late Harvey Cushing) the first chapters cover the administrative efforts in the early years which led to such efficient organization that neurosurgery finally came of age. It was then properly given an important role as a specialty which eventually led to the establishment of a ceiling of 21,900 neurosurgical beds in the zone of the interior in anticipation of the casualty load in 1945. During World War I, head injuries were treated chiefly by general and orthopedic surgeons.

The achievement of the neurologic surgeons in World War II is remarkable. The training of competent medical personnel in neurosurgical centers

made skilled neurosurgical treatment available to casualties who in World War I were considered hopeless.

Twelve outstanding neurosurgeons have contributed to this excellent book which includes chapters on (1) the management of acute craniocerebral injuries due to missiles; (2) penetrating wounds of the cerebral ventricles; (3) blast concussion; (4) cranioplasty; and (5) post-traumatic epilepsy.

Chemotherapy and antibiotics contributed to the brilliant achievement in the treatment of head injuries. Case reports are included. These illustrate the reluctance of the neurosurgeon to regard any head injury as too severe to be despaired of.

The programs developed for the rehabilitation of the casualty with a cerebral injury constituted another great advance.

Let us hope that this volume will remain chiefly of historical value; but, should another great conflict occur it will be of inestimable value in the treatment of casualties resulting from such a conflict. And there is much to be gained in this volume that is applicable to peace-time practice.

Volume II, dealing with spinal cord and peripheral nerve injuries, will be awaited with great anticipation.

WILLIAM EHRLICH, M.D.

The Power of Sexual Surrender. By Marie N. Robinson, M.D. Garden City, (N.Y.) 1959. Doubleday. Pp. 263. ($4.50)

Two reviewers have examined this book. The second reviewer is a gynecologist, the first reviewer is a woman.

The cerebral approach to sexuality offers no quick cure to women who have no fun in bed. In 263 pages, Dr. Marie Robinson, a New York psychiatrist, dissects the frigidity of a large section of American womanhood. Forty per cent is the figure she cites as being incapable of mature sexual partnership.

This book is cool, man! Here is no purple prose, no provocative imagery, no emotional overtone so frequent in such a treatise, designed—as this is—for lay use. There is assurance, of course, that a woman working seriously with a psychiatrist can overcome her sexual difficulty. This is the ideal solution. But lacking this opportunity for reaching self-fulfillment, Dr. Robinson offers, step by step, a "do-it-yourself-formula." Far from easy, such a course as she advocates offers promise to the female with fortitude enough to take herself in hand.

The implication is that every woman with a sexual problem should work hard at curing it, since sexual adjustment is the major factor in happy marriage—a highly debatable premise. The author presents an interpretation of the causes and cures of frigidity with self-surrender the goal to complete fulfillment.

The notion that men are responsible for their wives' lack of responsiveness is dispelled as an outmoded concept. So, shed your guilt, boys! You are not to blame after all. It all goes back to childhood and improper upbringing. Doesn't everything? And forward march, girls! "It goes without saying that the success of his marriage (to a frigid female like you) is dependent on the resolution of the *wife's* problem." Why does it go without saying?

Dr. Robinson has a final hint for the female still unfulfilled after following all this advice. This is contained in Addendum I where sources of outside help are listed. Addendum II is a list of additional books—popular and technical—which offer further exploration for the intelligent layman—or shall we say, *les girls?*

GENEVA GARNER

The Power of Sexual Surrender. By Marie N. Robinson, M.D. Garden City, (N.Y.) 1959. Doubleday. Pp. 263. ($4.50)

The author's thesis seems to be this: sex is the prime factor in marital happiness and a woman's inability to achieve orgasm is the major reason for sexual maladjustment. This kind of frigidity is due to a woman's unconscious desire to compete with a man, or to an unconscious rejection of her own femininity.

Every item in this thesis is controversial and every one has been denied by one authority or another. At one point Dr. Robinson (a psychiatrist and psycho-analyst) says that frigidity is rooted in ignorance and that books and counselling can do much to dissipate the ignorance. At another point she says it is a neurotic phenomenon of unconscious origin—and, presumably could be alleviated only by psychotherapy—certainly not by any rational approach like book-reading.

Dr. Robinson is enchanted by the difference between vaginal orgasm and clitoral orgasm and repeatedly scolds women whose orgasm is centered in the clitoris. (She views this as a masturbation equivalent—a sign of immaturity).

The suggested treatment technic includes knowledge, self-communion, taking pride in the female role, and eagerness to surrender.

The book presents an interesting approach—though one may quarrel with any of the basic themes listed at the beginnng of this review. I don't know what the psychiatrists would say, but most gynecologists would surely brand as a crotchet this belabored distinction between orgasm in the vagina and orgasm in the clitoris. This book (which has no index) is worth giving to a sophisticated woman who suffers from the kind of frigidity described here. Before prescribing the book, the doctor should read it himself. Dr. Robinson's basic concept is summed up in her statement that "Woman's excitement comes from the act of surrender." Few males will quarrel with her on that.

VICTOR HUBERMAN, M.D.

Trifluor Perazine. Edited by Henry Brill, M.D. Philadelphia 1958. Lea and Febiger. Pp. 219. ($3.50)

Trifluor perazine is the generic name for a Smith, Kline and French product which they tradename Stelazine®. This book collects 23 papers on the use of trifluor perazine. According to the contributors this drug makes lethargic patients brighter, calms aggressive patients, yet (paradoxically) it stirs the sluggish ones. Some investigators even found that trifluor perazine caused hallucinations and delusions to disappear. Two deaths (respiratory failure) were reported. In the index, there are no references to contra-indications, nor to side-effects. Many of the authors, however, reported side-effects. One said that the incidence of side-effects was greater with this drug than with other phenothiazines. No papers antagonistic to the drug were included. Forrester's paper (which found trifluor perazine "unacceptable") is not even listed in the bibliography nor does the name Forrester appear in the index. The 23 contributors are enchanted.

HENRY A. DAVIDSON, M.D.

Navy Surgeon. By Rear Admiral Herbert Lamont Pugh, Medical Corps, U.S.N., (Retired). Philadelphia, 1959. Lippincott. Pp. 459. ($5.00)

In this interesting autobiography, Admiral Pugh, who spent 35 years in the service of his country, reviews his life and work in honest fashion. A product of an observant eye and a facile pen, this book is a rich chronicle of adventure and professional life—written in a readable style.

Lamont Pugh served his nation in years of peace and during three wars. He enlisted in the Marine Corps during World War I; was Chief of Surgery at the Naval Hospitals at Pearl Harbor and San Diego during World War II; and was Surgeon General of the Navy during the Korean conflict. Accounts of duty ashore and at sea during his military career provide the reader with a fascinating travelogue, having—as might be expected—a noticeably medical flavor.

With frankness and wit, Dr. Pugh tells of his boyhood and education in Virginia, and his long and varied naval service. He describes unusual patients attended, interesting and eminent people met, and travels to exotic and remote places around the world. His visits to Africa, the Far East and Russia while Surgeon General comprise a modern Odyssey. Blended into this spectrum of naval medical activity, the Admiral injects candid comments on history, government and politics, and his own philosophy of life. The last third of this book, called "Vintage Years," is especially significant because of its proximity to pressing world problems today. A conversational style makes this volume easy and at times fascinating reading.

After reviewing his professional career from junior medical officer to Navy Surgeon General, the author concludes that the life of a service doctor offers many satisfactions to persons choosing this career.

The reviewer met Admiral Pugh and heard him speak on several occasions during his Navy medical service. Admired and respected by all who know him, Lamont Pugh is a gentleman who has brought dignity and honor to the Medical Corps of the Navy in his time. *Navy Surgeon* now makes available to all readers the distinguished record of this active and perceptive physician.

FRED B. ROGERS, M.D.

Fundamentals of Otolaryngology. By Lawrence R. Boies, M.D. Ed. 3. Philadelphia 1959, Saunders. Pp. 510. ($8.00)

Dr. L. Boies and his seven associates have revised the second edition of *Fundamentals of Otolaryngology* and have improved a manual which has received wide acceptance by medical students and general practitioners. The book is geared especially for medical students and general practitioners.

The book is easy to read. Illustrations are clear, simple, and informative. The references at the end of each chapter are sufficient for the interested physician to look for further information if he so desires.

Surgical technics have been reduced to a minimum which is good judgment because the physicians for whom this book is intended are not qualified to perform any extensive procedures. However, indications are presented for recognizing the necessity for further available surgical procedures.

I would especially commend the chapters written by Dr. Anderson C. Hilding on "Applied Anatomy and Physiology of the Nose" and "The Common Cold." These are clear, concise, and devoid of debatable material. Other good sections include the one on "Modern Medication in Otolaryngology" and Hilger's chapters on "tinnitus" and "vertigo."

In every day general practice, diseases of the ear, nose, and throat make up a good proportion of the patients seen in the office. The medical student and general practitioner need a quick, ready, and simple reference book handy. This is such a book. None of the topics are too specialized for him. Dr. Boies and his associates have made a successful effort to simplify a specialized subject. They have even condensed and simplified the preclinical subjects of anatomy, physiology, and pathology of the ear, nose and throat.

The author's purpose as described in his preface was to offer fundamental knowledge to the undergraduate student and the non-specialist. He has succeeded amply.

HENRY Z. GOLDSTEIN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

OCTOBER, 1959 • VOL. XXXII, No 8

SURVIVAL IN LUNG CANCER

Data are presented on 250 consecutive cases of of primary bronchogenic carcinoma from two Philadelphia survey units. The five year survival rate (17%) was calculated from the date of the first abnormal film. A plea is made for semiannual chest x-rays of asymptomatic older persons.

Despite a marked improvement in operative mortality five-year survival rates for primary lung cancer range between 4.1 and 9.6 per cent. This may be due to an inherent biologic tendency to early metastasis, to late diagnosis or to inadequacy of current therapeutic measures. Little is known about the natural history of bronchogenic carcinoma. Tumors vary in rates of growth and in invasive and metastasizing qualities.

A major difficulty in the whole field of prognosis is the lack of a classification of lung cancer that would permit comparison of different series in the same manner in which cases of tuberculosis can be compared according to extent of disease. Surgeons have reported five-year survival rates of about 35 per cent for cases resected while lesions are localized, in contrast to 4 to 9 per cent for resected patients whose cancer has spread. Such figures place the burden of earlier detection upon physicians who see patients with cancer before surgeons see them. Periodic x-ray examinations of the chest are the only current approach to the detection of lung cancer in asymptomatic persons. It is important to stress this because of the current anxiety about radiation hazards. Lung cancer is a fatal disease. One must balance the risks of failing to find this illness early enough for curative resection against the theoretical risks of leukemia and osteogenic sarcoma.

METHOD

Two hundred and fifty consecutive cases of primary lung cancer surveyed at two official Philadelphia chest x-ray units between February, 1947, and December, 1956, were followed through March, 1957. No case was lost to follow-up study. In addition to the usual data an attempt was made to classify the types of abnormalities appearing on the first abnormal x-ray films and to correlate them with survival rates. The clinical diagnosis of concomitant active tuberculosis was accepted only if there was more than one positive sputum report. Survival rates were based on five years when numbers were adequate, otherwise on three.

RESULTS

Over-all Survival. The five-year survival rate was 17 per cent, well above that reported by surgeons. It is noteworthy that one man lived for nine years after his first abnormal film despite not having had a resection.

Survival According to Operation. Of the 250 patients, 133 were explored, and 73 were resected. The five-year survival rate in the small group (30 cases) with resection in the study long enough to calculate such a rate was 37 per cent—about the figure reported by surgeons for patients resected while their tumors were still localized.

Survival According to Age. The five-year survival rate was 20 per cent for 59 persons over the age of fifty-five, as compared to 12 per cent for 41 under that age. No regular pattern of survival in relation to age is reported.

KATHERINE R. BOUCOT, M.D., UTAKO HORIE, M.D., AND MARTIN J. SOKOLOFF, M.D., *New England Journal of Medicine, April* 9, 1959.

Survival According to Race. There is an impression in the literature that there is less cancer in Negroes than in whites. This has not been the experience of official Philadelphia surveys, in which the prevalence rate for men over forty-five is 422 for nonwhites as compared to 215 per 100,000 for whites. Similar results have been reported by the Philadelphia Pulmonary Neoplasm Research Project.

Tissue Type in Relation to Sex. Of the 228 men in the study, 54 per cent had squamous-cell cancer; only four of the 22 women had it.

If squamous-cell carcinoma is related to exogenous carcinogens, the greater proportion of squamous-cell carcinoma in men may be due to a greater industrial exposure. However, the small groups involved in this study are not statistically significant.

So far as survival is concerned, squamous-cell carcinoma seems to be a different disease from adenocarcinoma and undifferentiated carcinoma. Not only are over-all survival rates better, but patients live longer after resection.

X-ray Classification for Prognostic Purposes. An elaborate classification was set up, but the only important correlation with prognosis was between tumors arising as solitary nodules and all other tumors.

Bronchoscopic Findings. Of the 213 patients given bronchoscopic examinations only 44 or 21 per cent, had normal gross findings. Cytologic specimens were normal in 35. The prognosis of this group was markedly better than that for the group with abnormalities on either gross or microscopical study.

Clinical Status. The survival of patients with cancer is related to their clinical status at the time of the first film abnormality. Fifty-eight per cent of 43 asymptomatic patients lived for three years; the figure was only 9 per cent for the 80 patients with clinically manifest disease.

DISCUSSION

There is widespread discouragement over the survival of patients with lung cancer. Surgeons have never achieved five-year survival rates better than 10 per cent, probably because of the late stage of the disease by the time of diagnosis. However, there is evidence that efforts to detect cancer early are rewarding. The 17 per cent five-year survival rate in this study is dated from the first radiologic abnormality at the cancer site. More than half the asymptomatic patients in our study lived for three years. Patients with resection before evidence of metastasis also have a better prognosis. In view of the current hysteria about radiation, it is extremely important to stress the effectiveness of periodic x-ray study of the chest for asymptomatic persons in the cancer age group. Early detection is the only key to cure.

Evaluation of therapy is rendered difficult by the lack of a uniform method of reporting survival rates.

Another problem in evaluating results is the paucity of basic data. Unless actual numbers of cases as well as percentages are presented, the true situation cannot be assessed.

The problem of "erroneous negative" x-ray reports is serious. Minute lesions are too often missed. Reduction of film-reading errors would materially improve survival rates.

A third problem is that of false reassurance when bronchoscopic or cytologic findings are normal. In the presence of otherwise undiagnosable abnormalities in older persons, such negative studies should not be construed as proof against carcinoma.

Pending the availability of cancerocidal agents, enhanced efforts to detect early lung cancer are of the utmost importance. These include semi-annual x-ray examinations of the chest of asymptomatic persons in the cancer age group who have respiratory symptoms. Meticulous prolonged follow-up study should be directed toward older persons with pneumonias even if response to antibiotic therapy has been prompt. Radiologists should over-read any x-ray abnormalities in the chest films of older people. Cancer should be suspected unless prompt proof is forthcoming that the lesions are benign.

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet 2:347 (Aug. 16) 1958.

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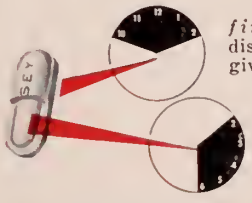
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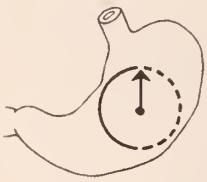
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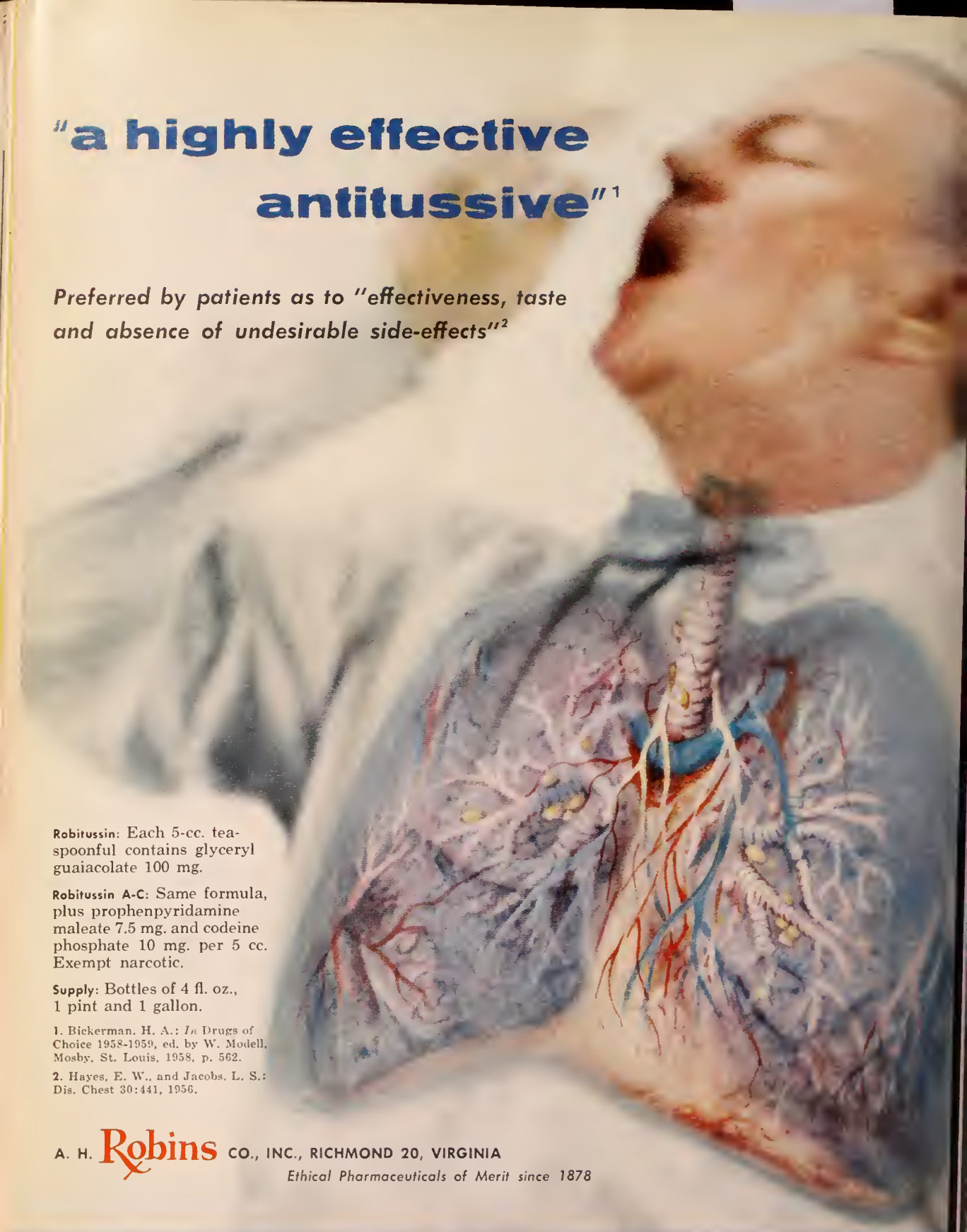
1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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1. Bickerman, H. A.: *In* Drugs of Choice 1958-1959, ed. by W. Modell, Mosby, St. Louis, 1958, p. 562.

2. Hayes, E. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956.

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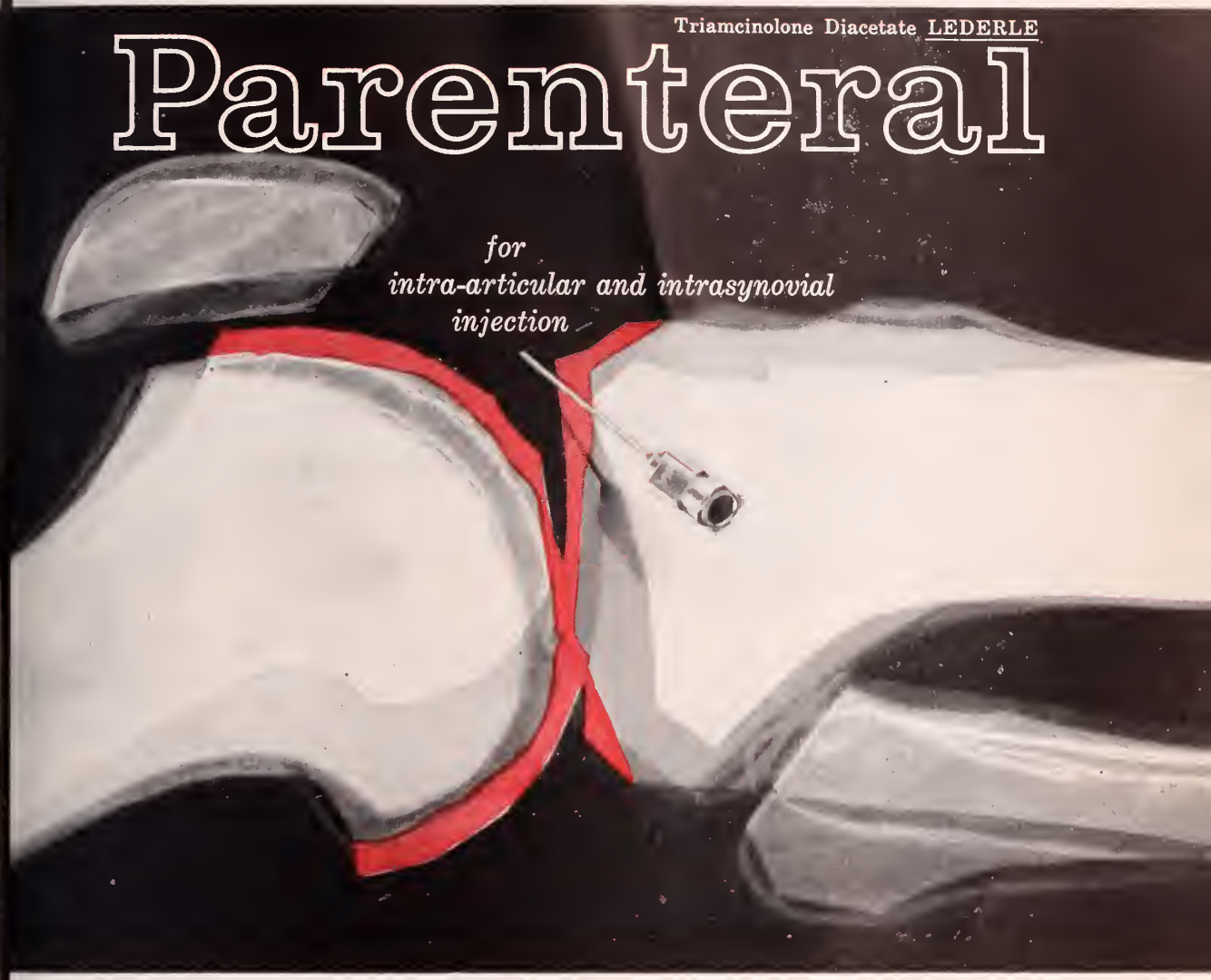
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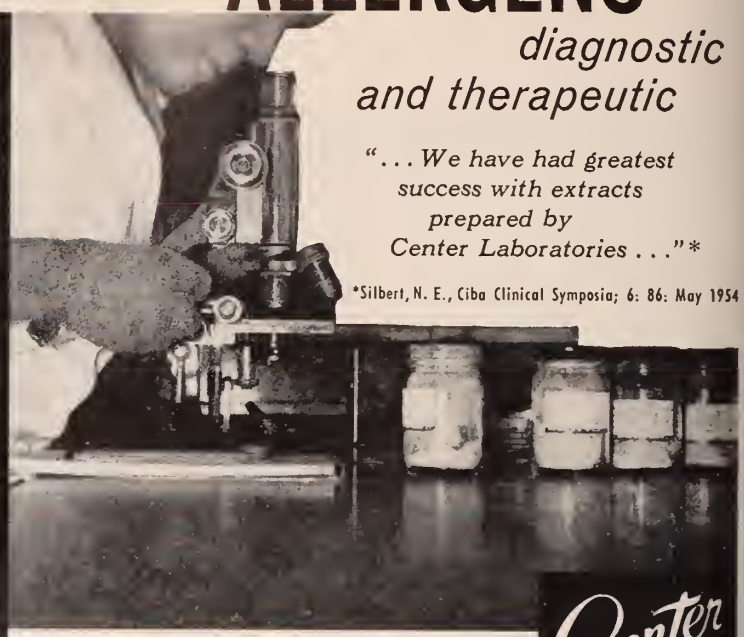
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1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

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CONTENTS—Pages 645 to 710

EDITORIALS— Page

Labelling the Prescribed Drug 645

Make This Caller Welcome! 646

Merck Memorial Fund 646

ORIGINAL ARTICLES—

Blue Shield Service Benefits: The Full Payment Concept—Nicholas F. Alfano, M.D., Newark, N. J. 647

Safer Diuresis—Mario Tami, M.D. and Milton Shoshkes, M.D., Newark, N. J. 652

Prevention of Fetal Trauma—Joseph P. Donnelly, M.D., Jersey City, N. J. 656

Parasitic Diarrheas—Samuel W. Eisenberg, M.D., Philadelphia, Pa. 661

Premedication for the Control of Postoperative Vomiting—C. A. Musetto, M.D., A. J. Ward, M.D. and Sally Gouveia, R.N., Boonton, N. J. 667

Skin Disease Involving Animal Contacts—H. C. Goldberg, M.D., *et al.*, Plainfield, N. J. 671

ORIGINAL ARTICLES— Page

Cardiovascular Disease Among Physicians—Norman Reitman, M.D., New Brunswick, N. J. 673

Endoscopic Resection of the Prostate—Stanley I. Glickman, M.D., New York, N. Y. 677

STATE ACTIVITIES—

Merck Memorial Fund 672

Trustees' Meeting, September 20, 1959 681

Golden Merit Award Ceremony 686

Medical-Surgical Plan Discussion 688

OBITUARIES 701

ANNOUNCEMENTS 702

COUNTY SOCIETY REPORTS 703

BOOK REVIEWS 706

NTA ABSTRACTS 709

Roster of Officers and Committee Chairmen, Advertising Page 3A

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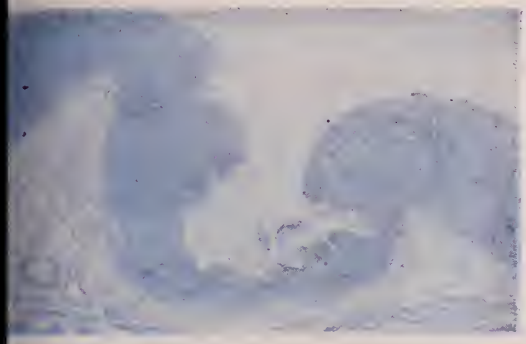
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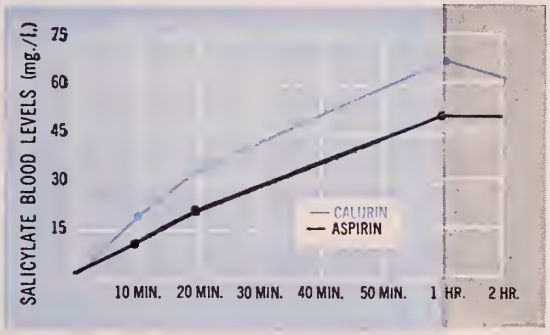
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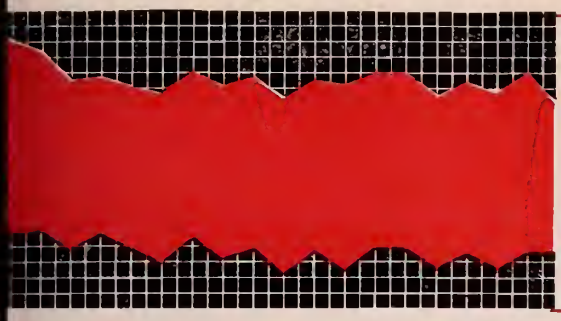
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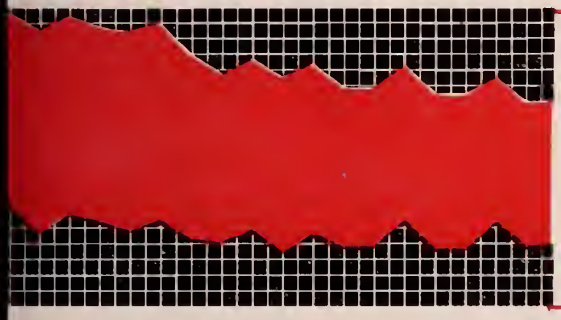
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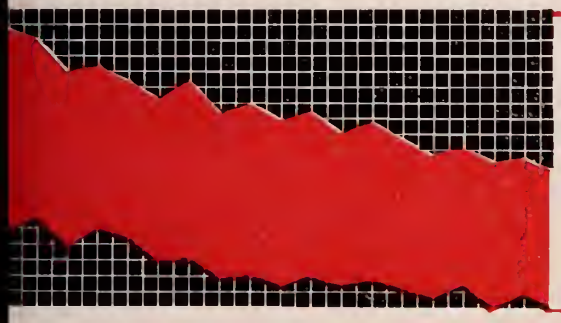
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- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25
25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

HYDROPRES-50
50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

*HYDRODIURIL AND HYDROPRES ARE TRADEMARKS OF MERCK & CO., INC.



Of course, women like "Premarin"®

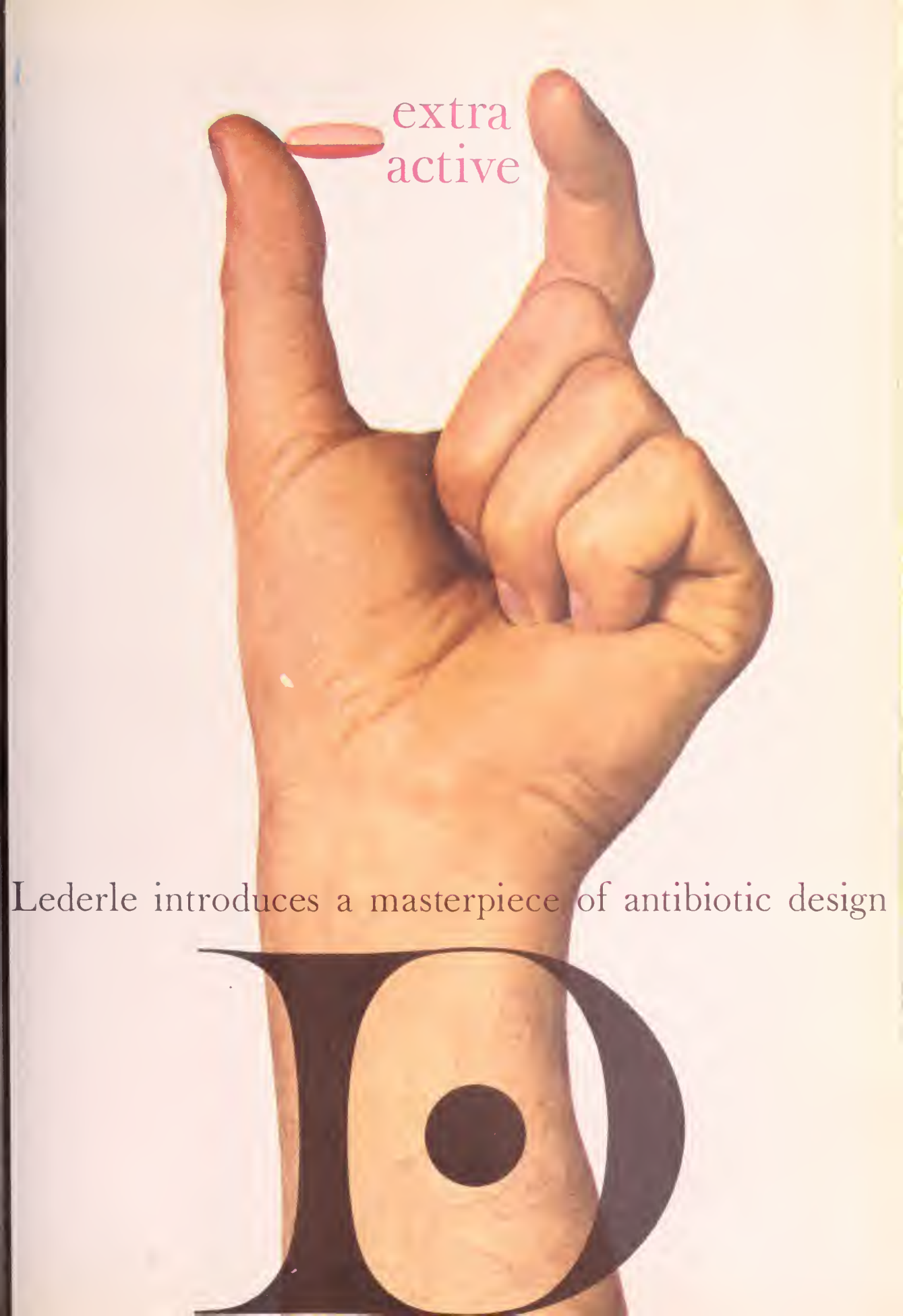
THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how e
it to be treated?), let your choi
"Premarin," a complete natur
trogen complex.

"Premarin," conjugated estr
(equine), is available as tablet
liquid, and also in combinatio
meprobamate or methyltestost

Ayerst Laboratories • New York
16, N. Y. • Montreal, Canada



Lederle introduces a masterpiece of antibiotic design

Strikingly enhances the traditional advantage of broad-spectrum antibiotics...

for greater patient-physician benefit

DECLOMYCIN is a unique fermentation product of a strain of *Streptomyces aureofaciens*—the parent organism of AUREOMYCIN®* and ACHROMYCIN.®†

DECLOMYCIN singularly achieves:

- greater antibiotic activity with far less drug
- greater stability in body media
- unrelenting peak activity throughout therapy
- "extra-day" protection through sustained activity

DECLOMYCIN retains:

- unsurpassed broad-spectrum range of activity
- rapid activity
- excellent toleration
- effectiveness against infection in nearly all organs or systems—rapid diffusion in body tissues and fluids

**Chlortetracycline Lederle* †*Tetracycline Lederle*

DECLO

Demethylchlortetracycline Lederle

Greater antibiotic activity with far less antibiotic

Milligram for Milligram, DECLOMYCIN exhibits 2 to 4 times the clinical potency (inhibitory action) of tetracycline against susceptible organisms. Thus, DECLOMYCIN has the advantage of providing significantly higher serum *activity* levels with significantly reduced drug intake.* [1,3,5]

Actually, DECLOMYCIN demonstrates the highest ratio of prolonged activity level to daily milligram intake of any known broad-spectrum antibiotic. Reduction of milligram intake of drug reduces hazards of related physical effect on intestinal mucosa or interaction with gastrointestinal contents.

*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value.[1]

MYCIN



Unrelenting peak antimicrobial attac throughout therapy

The high level of DECLOMYCIN activity is uniquely sustained. It is not just an initial phenomenon but is constant—maintained on each day of treatment and between doses—without noticeable diminution of intensity. Peak-and-valley control is eliminated, favoring continuous suppression of pathogens and consequent improvement.

This DECLOMYCIN constant is achieved through remarkably greater stability in body fluids,[2,4,6] resistance to degradation[6] and a low rate of renal clearance[4,5]—all supporting antibiotic activity for extended periods.

DECLO

Demethylchlortetracycline Lederle

"Extra-day" activity for security against relapse

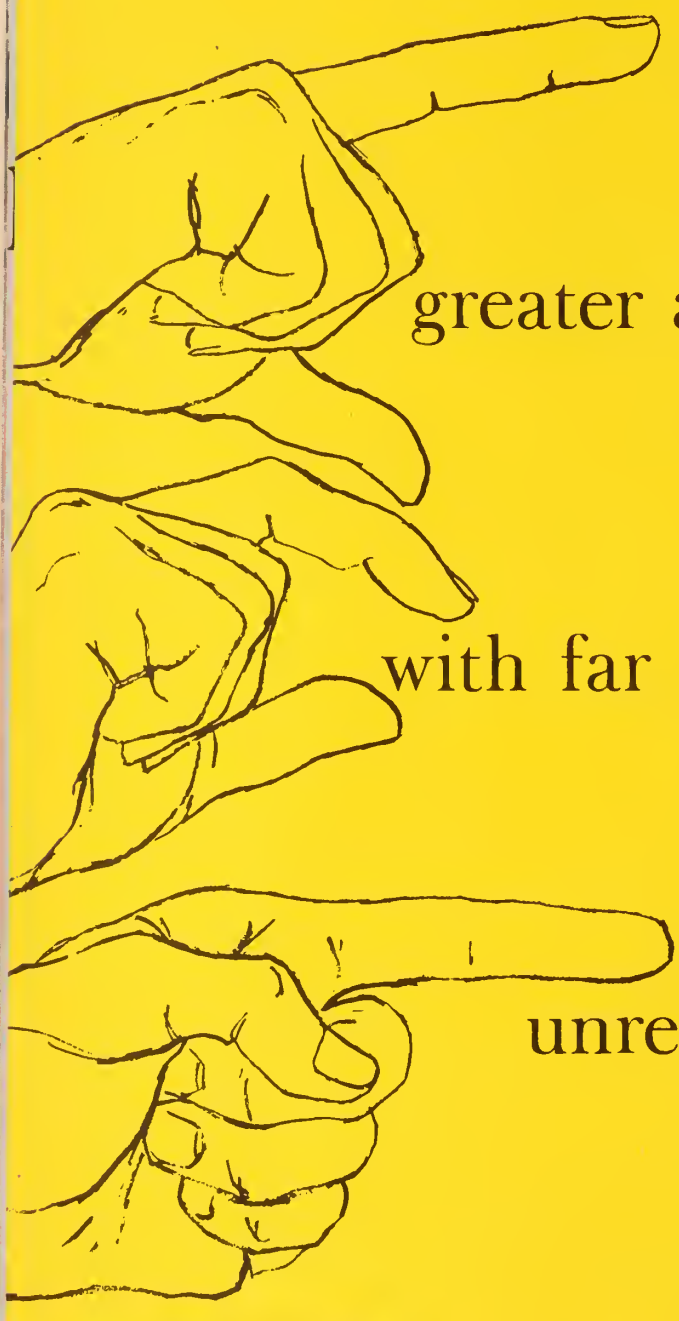
DECLOMYCIN maintains significant antibacterial activity for one to two days after discontinuance of dosage[1]—a major distinction from other antibiotics. Previous drugs have declined abruptly in activity following withdrawal.

DECLOMYCIN thus gives the patient an unusual degree of protection against resurgence of the primary infection, and against secondary infection... sequelae not infrequently encountered and often resembling a "resistance problem." Consequently, reinstitution of therapy or a change in therapy should rarely be necessary.

MYCIN



A masterpiece o



greater antibiotic activity

with far less antibiotic intak

unrelenting peak attack

—enhancing the unsurpassed features of tetracycline . . . for greater physician-patient benefits

DECLO

Demethylchlortetracycline Lederle

ntibiotic design

plus
"extra-
day"
activity

FOR PROTECTION
AGAINST
RELAPSE



MYCIN

A major contribution of Lederle research



in the distinctive dry-filled duotone capsule

DECLOMYCIN

Demethylchlortetracycline Lederle

available as:

DECLOMYCIN Capsules, 150 mg.
Adult dosage: 1 capsule four times daily.
Pediatric Drops, 60 mg. per cc.
Bottles of 10 cc. with dropper.
Oral Suspension, 75 mg. per 5 cc. tsp.

1. Hirsch, H. A., and Finland, M.: Antibacterial Activity Of Serum Of Normal Subjects After Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959. 2. Hirsch, H. A., Kunin, C. M., and Finland, M.: Demethylchlortetracycline – A New And More Stable Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. To be published. 3. Lichter, E. A., and Sobel, S.: The Distribution Of Oral Demethylchlortetracycline In Healthy Volunteers And In Patients Under Treatment For Various Infections. To be published. 4. Kunin, C. M., Dornbush, A. C. and Finland, M.: Distribution And Excretion Of Four Tetracycline Analogues In Normal Young Men. To be published. 5. Kunin, C. M., and Finland, M.: Demethylchlortetracycline: New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Capacity. *New England J. Med.* 259:999 (Nov. 20) 1958. 6. Sweeney, W. M.; Hardy, S. M.; Dornbush, A. C., and Ruegsegger, J. M.: Demethylchlortetracycline: A Clinical Comparison of A New Antibiotic with Chlortetracycline and Tetracycline. *Antibiotics & Chemotherapy* 9:13 (Jan.) 1959.

Rx

Declomycin Caps
150 mg.
Disp # XVI
Sig 1 cap q.i.d.

LEDERLE LABORATORIES,
a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York

Lederle

NOW many more hypertensive patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

cept for one case of mild blood-pressure elevation (150/90) **no hypertension s seen in any of 1500 patients†** as a result of treatment with DECADRON—the w and, on a milligram basis, most potent of all corticosteroids. **Hypertension luced by other steroids diminished or disappeared.**

Thus with DECADRON, hypertension no longer appears to be a contraindication to successful corticosteroid therapy. And the dramatic therapeutic impact of DECADRON was virtually unmarred by diabetogenic or psychic reactions . . . Cushingoid effects were fewer and milder . . . and there were no new or "peculiar" side effects. Moreover, DECADRON helped restore a "natural" sense of well-being.

†Analysis of clinical reports.

*DECADRON is a trademark of Merck & Co., Inc. ©1959 Merck & Co., Inc.

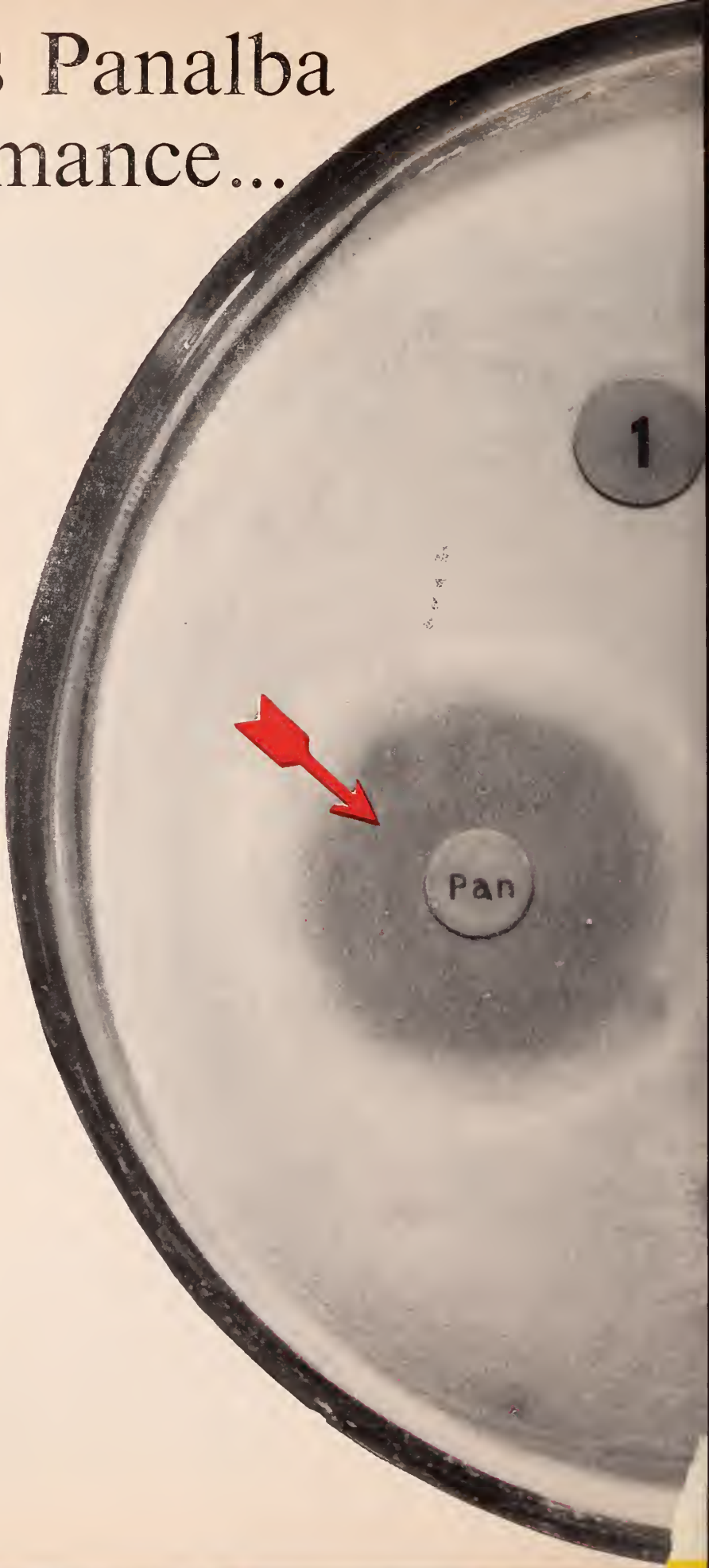
ecadron*

XAMETHASONE

eats more patients ore effectively

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

This is Panalba performance...





in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



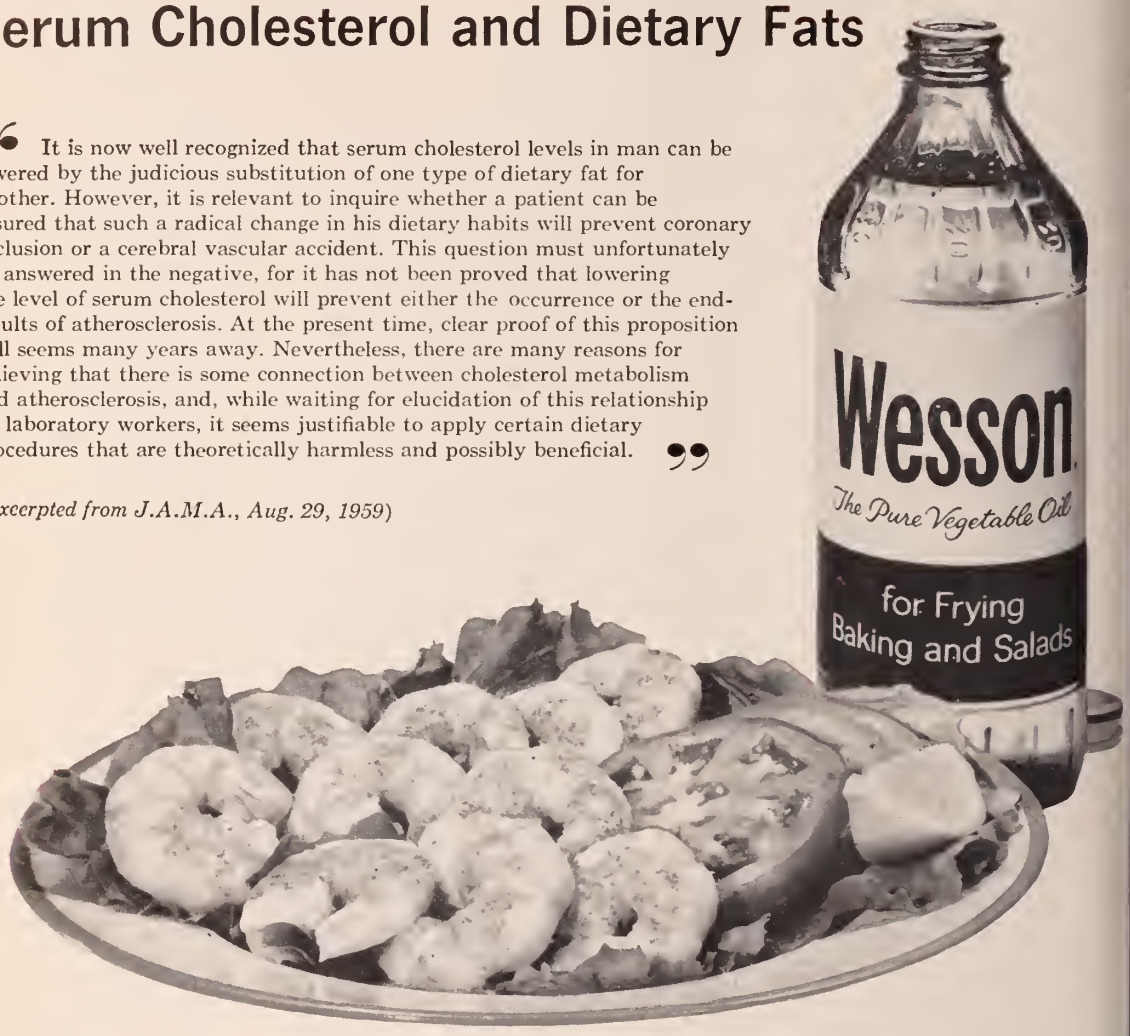
Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.

A Significant Statement about Serum Cholesterol and Dietary Fats

"It is now well recognized that serum cholesterol levels in man can be lowered by the judicious substitution of one type of dietary fat for another. However, it is relevant to inquire whether a patient can be assured that such a radical change in his dietary habits will prevent coronary occlusion or a cerebral vascular accident. This question must unfortunately be answered in the negative, for it has not been proved that lowering the level of serum cholesterol will prevent either the occurrence or the end-results of atherosclerosis. At the present time, clear proof of this proposition still seems many years away. Nevertheless, there are many reasons for believing that there is some connection between cholesterol metabolism and atherosclerosis, and, while waiting for elucidation of this relationship by laboratory workers, it seems justifiable to apply certain dietary procedures that are theoretically harmless and possibly beneficial."

(Excerpted from J.A.M.A., Aug. 29, 1959)



Where a poly-unsaturated oil is called for in the diet, Wesson satisfies the most exacting requirements (and the most exacting appetites).

To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson,* particularly by the criteria of odor, flavor (blandness) and lightness of color.

Uniformity you can depend on. Wesson has a *poly*-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson, and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.

Each pint contains 437—524 Int. Units of Vitamin E.

Wesson's Important Ingredients:

Linoleic acid glycerides	50% to 55%
Phytosterol (predominantly beta sitosterol)	0.4% to 0.7%
Total tocopherols	0.09% to 0.12%

Never hydrogenated—completely salt free

*Reconfirmed by recent tests against the next leading brand with brand identifications removed, among a national probability sample.

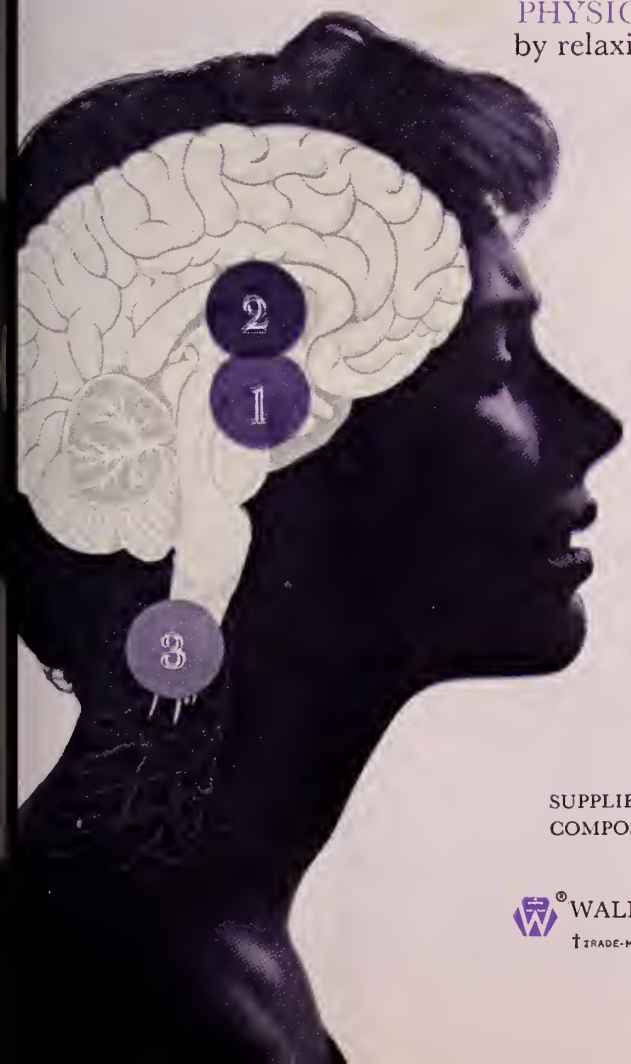
COMPREHENSIVE, THREE-LEVEL TREATMENT OF DEPRESSION

AND ASSOCIATED ANXIETY AND PHYSICAL TENSION

RELIEVES DEPRESSION
including symptoms such as crying, lethargy, loss of appetite, insomnia

RELIEVES ASSOCIATED ANXIETY
with no risk of drug-induced depression

RELIEVES ASSOCIATED PHYSICAL TENSION
by relaxing skeletal muscle



1
hypothalamus

2
thalamus and limbic system

3
spinal cord

▲Deprol▲†

benactyzine + meprobamate

- confirmed efficacy
- documented safety

SUPPLIED: Bottles of 50 light-pink, scored tablets
COMPOSITION: Each tablet contains 1 mg. benactyzine HCl and 400 mg. meprobamate

®WALLACE LABORATORIES • *New Brunswick, N. J.*
†TRADE-MARK.
CD-9290

If one . . . or all . . . needs nutritional support . . .



they
deserve

GEVRAL®

capsules—14 VITAMINS AND 11 MINERALS

Vitamin-Mineral Supplement Lederle

For Complete Formula see PDR (Physicians' Desk Reference), page 689

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

NEO-SYNEPHRINE® COLD TABLETS

COMPOUND

CONTROL OF COMMON COLD SYMPTOMS with

Neo-Synephrine Compound Cold Tablets is pharmacologically comprehensive and clinically practical...

COMPREHENSIVE because in this new preparation are rationally combined drug actions that are needed to control the common cold symptomatology "across the board"

PRACTICAL because the average patient will promptly find relief from his distress.

For full-range symptomatic relief orally each tablet of Neo-Synephrine Compound provides:

VS. NASAL STUFFINESS, TIGHTNESS—
Neo-Synephrine hydrochloride...5 mg.
pre-eminent, orally effective decongestant

VS. ACHES, CHILLS, FEVER—
Acetaminophen (N-acetyl-*p*-aminophenol)...150 mg.
modern analgesic and antipyretic

VS. RHINORRHEA—
Thenfadil* hydrochloride ...7.5 mg.
effective, well tolerated antihistaminic

VS. LASSITUDE, MALAISE—
Caffeine...15 mg.
dependable, mild, stimulating agent

DOSAGE: *Adults*—2 tablets three times a day

Children 6 to 12 years—
1 tablet three times a day

Bottles of 20 and 100 tablets

Winthrop LABORATORIES

AGAINST THE ENTIRE COLD SYNDROME

STUFFINESS

ACHES

RHINORRHEA

FEVER

MALAISE

ONE FORMULA

TO CLEAR THE AIRWAY

topically
in colds,
sinusitis
and allergic
rhinitis

NTZ®

Nasal Spray

quick
and
lasting
decongestion



Combining three effective intranasal medications, NTZ produces sustained decongestion ...aeration...sinus drainage. There are virtually no side effects, and NTZ maintains therapeutic action with repeated use. NTZ is available in a convenient, nonbreakable plastic squeeze bottle of 20 cc. that delivers a fine, even spray and does not leak. Even small children use it easily.

***N**eo-Synephrine* hydrochloride, 0.5% –*
accepted vasoconstrictor and decongestant

***T**henfadil* hydrochloride, 0.1% –*
dependable topical antihistaminic

***Z**ephiran† chloride, 1:5000 –*
antibacterial wetting agent and preservative

Winthrop LABORATORIES *New York 18, N.Y.*

*TZ Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride (cationic), trademarks reg. U.S. Pat. Off.

RESEARCH:

key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.



The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!



OFFERS HIGHER BLOOD LEVELS—FASTER—THAN ANY OTHER SALT OF ORAL PENICILLIN:

COMPOCILLIN®-VK

Potassium Penicillin V

Supplied: Compocillin-VK Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. When reconstituted, each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

ABBOTT

® FILMTAB — FILM-SEALED TABLETS, ABBOTT U.S. PAT. NO. 2881085

in tiny, easy-to-swallow Filmtabs® in tasty, cherry-flavored Oral Solution

908129



Each tablet contains: Iron (Ferrous Sulfate Exsiccated 194 mg.), 58 mg.; Dioctyl Sodium Sulfosuccinate, 100 mg.; Vitamin A, 6000 U.S.P. Units; Vitamin D, 400 U.S.P. Units; Vitamin B_1 (Thiamine Mononitrate), 5 mg.; Vitamin B_2 (Riboflavin), 5 mg.; Vitamin B_6 (Pyridoxine HCl), 2 mg.; Vitamin B_{12} Activity (Cobalamin Conc.), 2 mcg.; Vitamin C, 100 mg.; Folic Acid, 0.25 mg.; Niacinamide, 20 mg.; Calcium Pantothenate, 5 mg., Calcium (Calcium Carbonate), 150 mg.; (Phosphorus free formula).

strength and vitality...
freedom from constipation



*TERMINATAL® (Tablets, Benton)

prenatal dietary supplement
high iron content in a potent nutritional formula
counteracts prenatal constipation
sensibly packaged in re-usable nursing unit
one-a-day dosage convenience

Addition of dioctyl sodium sulfosuccinate to offset constipation of pregnancy by fecal softening makes TERMINATAL a *unique* high-potency dietary supplement for use to term.

Supplied: 100 TERMINATAL capsule-shaped tablets are packaged in a useful nursing bottle with nipple, ready for the infant's first formula.

BENTON Laboratories Hatboro, Pennsylvania
Division of Air-Shields, Inc.



WHENEVER COUGH THERAPY IS INDICATED

Hycomine®

SYRUP

THE *complete* Rx FOR COUGH CONTROL

cough sedative / antihistamine / expectorant

- relieves cough and associated symptoms in 15-20 minutes
- effective for 6 hours or longer
- promotes expectoration
- rarely constipates
- agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

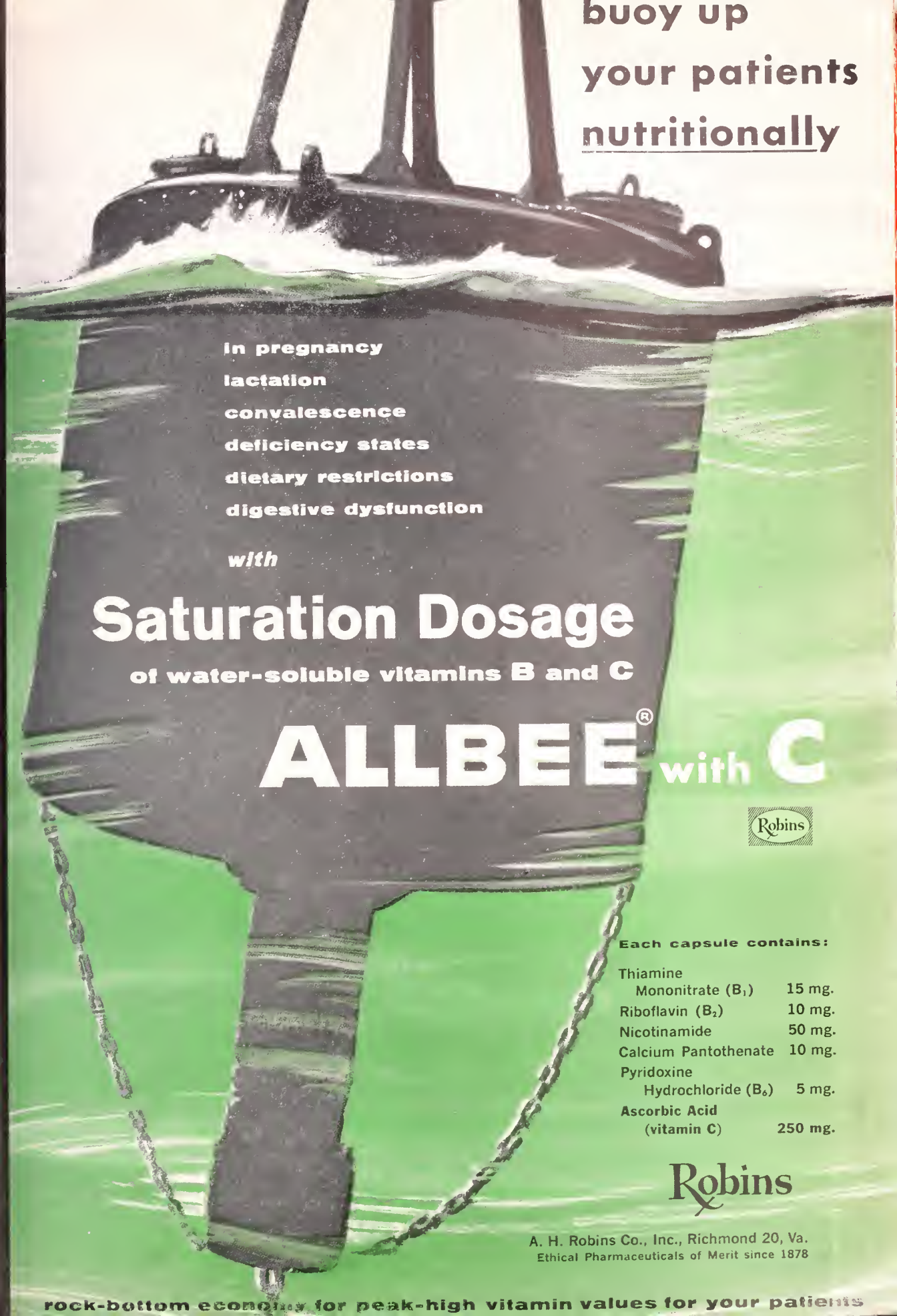
Supplied: As a pleasant-to-take syrup. May be habit-forming. Federal law permits oral prescription.

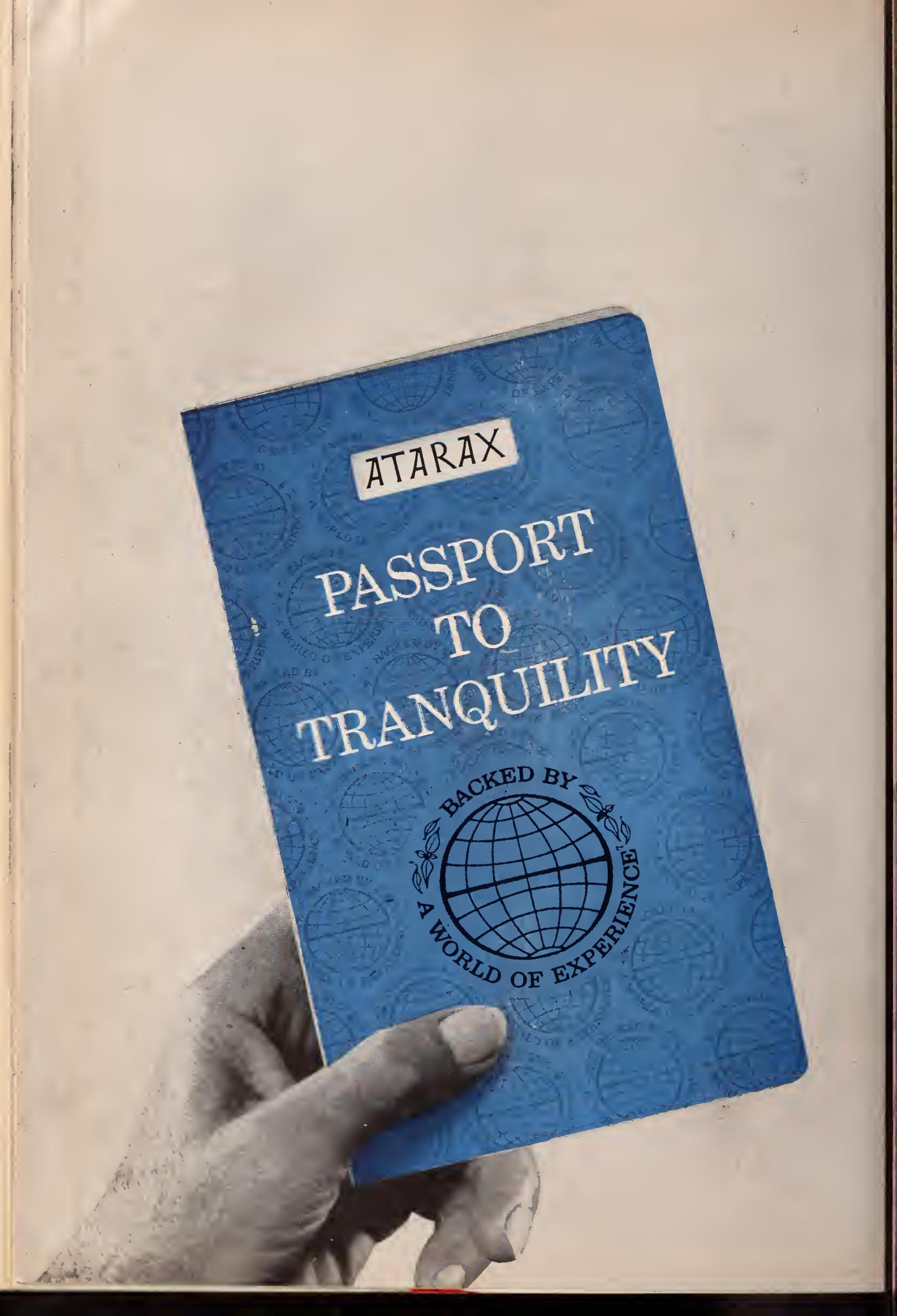
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U.S. Pat. 2,630,400


buoy up
your patients
nutritionally
in pregnancy
lactation
convalescence
deficiency states
dietary restrictions
digestive dysfunction
with
Saturation Dosage
of water-soluble vitamins B and C
ALLBEE® with C
Robins
Each capsule contains:
Thiamine Mononitrate (B_1) 15 mg.
Riboflavin (B_2) 10 mg.
Nicotinamide 50 mg.
Calcium Pantothenate 10 mg.
Pyridoxine Hydrochloride (B_6) 5 mg.
Ascorbic Acid (vitamin C) 250 mg.
Robins
A. H. Robins Co., Inc., Richmond 20, Va.
Ethical Pharmaceuticals of Merit since 1878
rock-bottom economy for peak-high vitamin values for your patients


ATARAX
PASSPORT
TO
TRANQUILITY
BACKED BY
A WORLD OF EXPERIENCE

Passport

☞ **a universal record of effectiveness**

In anxiety, tension and agitation, ATARAX "... produced a more favorable state of calm and tranquility than any drug previously used."[1]

☞ **widest latitude of safety and flexibility**

No serious adverse reaction ever documented – five dosage forms and sizes

☞ **chemically distinct among tranquilizers**

Not a phenothiazine or a meprobamate

☞ **added frontiers of usefulness**

These unique benefits in specific indications

ANTIHISTAMINIC
ANTIARRHYTHMIC
ANTISECRETORY

BACKED BY A WORLD OF EXPERIENCE

Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN – 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

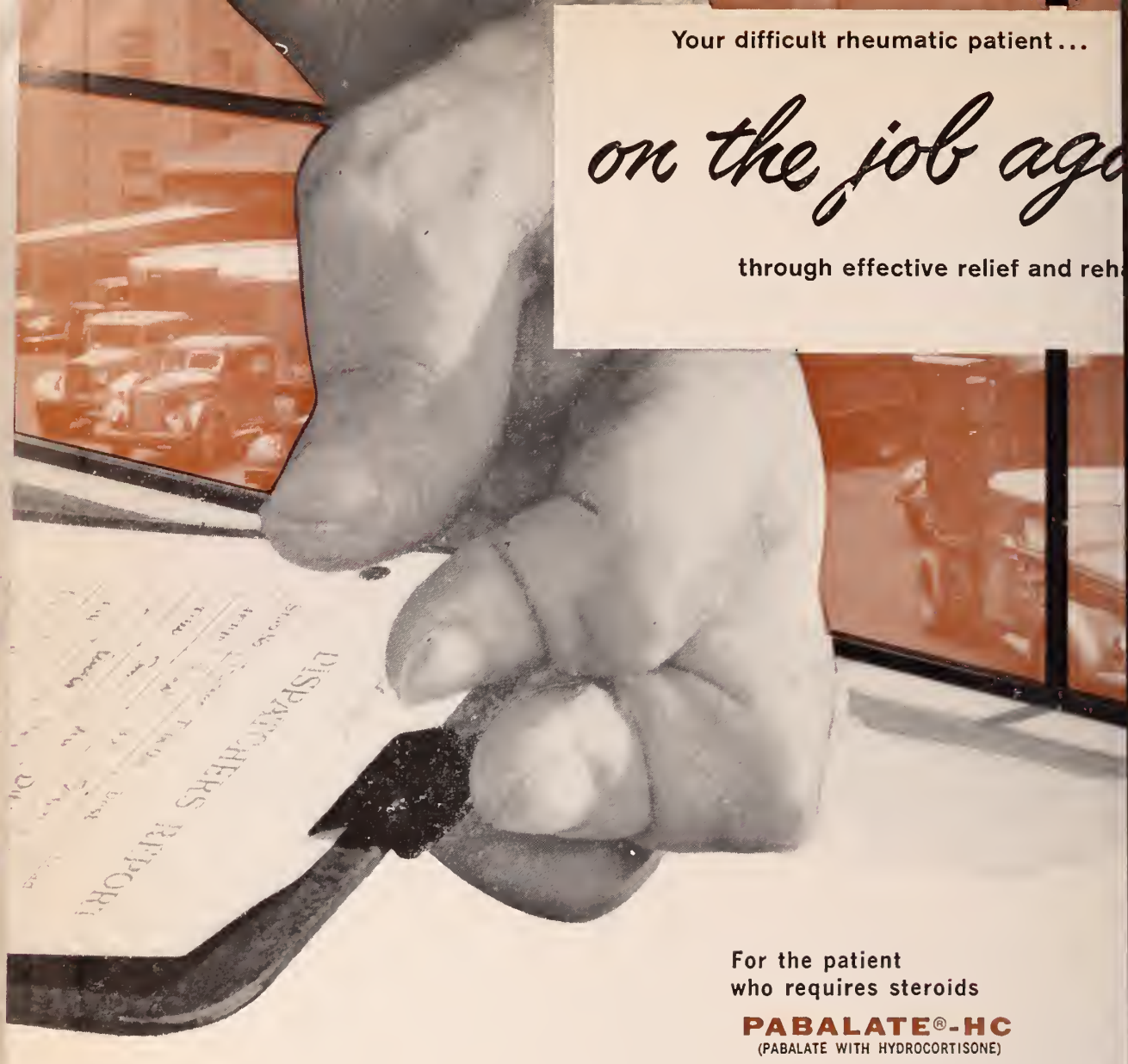
References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

ATARAX®

PASSPORT TO TRANQUILITY

nd of hydroxyzine)

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being



Your difficult rheumatic patient...

on the job ago

through effective relief and reha

For the patient who does not require steroids

PABALATE®

Reciprocally acting nonsteroid antirheumatics . . . more effective than salicylate alone.

In each enteric-coated tablet:

Sodium salicylate U.S.P.....0.3 Gm. (5 gr.)
Sodium para-aminobenzoate .....0.3 Gm. (5 gr.)
Ascorbic acid .....50.0 mg.

or for the patient who should avoid sodium

PABALATE® - Sodium Free

Pabalate, with sodium salts replaced by potassium salts.

In each enteric-coated tablet:

Potassium salicylate .....0.3 Gm. (5 gr.)
Potassium para-aminobenzoate .....0.3 Gm. (5 gr.)
Ascorbic acid .....50.0 mg.

For the patient who requires steroids

PABALATE®-HC

(PABALATE WITH HYDROCORTISONE)

Comprehensive synergistic combination of steroid and nonsteroid antirheumatics... full hormone effects on low hormone dosage . . . satisfactory remission of rheumatic symptoms in 85% of patients tested.

In each enteric-coated tablet:

Hydrocortisone (alcohol) ..... 2.5 mg.
Potassium salicylate ..... 0.3 Gm.
Potassium para-aminobenzoate.. 0.3 Gm.
Ascorbic acid .....50.0 mg.

PABALATE® Robins PABALATE-HC

For steroid or non-steroid therapy: SAFE DEPENDABLE ECONOMICAL

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA • Ethical Pharmaceuticals of Merit since 1878

Why should I use **KANTREX**® Injection* when there are so many other antibiotics available?

Because KANTREX Injection is bactericidal to a wide variety of organisms, including many that are highly resistant to the other antibiotics [4,10,12-14,17,18,20,21,23,24,25,27,30,33,35,37]

—organisms such as *Staph. aureus, Staph. albus, A. aerogenes, E. coli, H. pertussis, K. pneumoniae, Neisseria* sp., *Shigella, Salmonella* and many strains of *B. proteus.*

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it also?*

Next page, please . . . . . .

*Kanamycin sulfate injection (Bristol)

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it also?*

A A very good question, but it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

Q *My impression is that* KANTREX *is just another neomycin. Isn't that so?*

A Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"[4]; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

Q *You mean that* KANTREX *Injection doesn't have the nephrotoxicity of neomycin?*

A Precisely. It's true that when KANTREX Injection is used, urinary casts – even slight albuminuria or microscopic hematuria – may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

Q *Then why do you recommend reduced dosage in patients with renal impairment?*

A Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

Q *Is that why we see reports of patients developing hearing loss during* KANTREX *Injection therapy?*

A Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can be achieved with a fraction of the dose suggested for patients with normal kidney function – with minimal risk of ototoxicity.

Q *Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use* KANTREX *Injection in such conditions?*

A Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus, A. aerogenes* and *E. coli*, even when renal impairment is present.

Q *What are the "proper precautions" in a patient with impaired renal function?*

A The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more

is seldom required because the clinical response to KANTREX Injection is so rapid.

Q *Why do you put so much emphasis on* KANTREX'S *"rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."*

A There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.[1,2,3,7,8,9,11,15,16,19,21,22,26,29,31,33] Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[20]

Q *Does* KANTREX *Injection cause blood dyscrasias?*

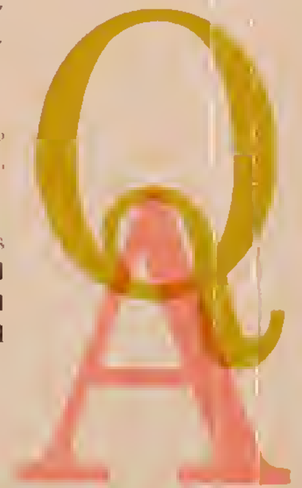
A In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

Q *Can I administer* KANTREX *Injection in any other way than by the intramuscular route?*

A Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

Q *So you think I might to use* KANTREX *Injection as my first choice antibiotic in staph and gram-negative infections?*

A Yes – because all evidence to date indicates that it is bactericidal against a wide range of organisms... rapid acting... does not encourage development of bacterial resistance... is well tolerated in specified dosage... and has not caused any blood dyscrasias.



KANTREX CAPSULES

for local gastrointestinal therapy...
not for systemic infections

Q *Why can't I use* KANTREX *Capsules for systemic medication?*

A Because there is only negligible absorption of KANTREX from the gastrointestinal tract.[3,5,6,8,28,34] Thus, capsules cannot provide effective blood levels.

Q *Then what are* KANTREX *Capsules used for?*

A Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q *I've been using neomycin for preoprative bowel sterilization. Why should I switch to* KANTREX *Capsules?*

A Because KANTREX has been rated as "superior to neomycin" for this purpose.[6] It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.[5,6]

Q *What advantages do* KANTREX *Capsules offer me in the treatment of intestinal infections?*

A A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella*, *Shigella*, *Staph. aureus*, *E. coli* and *Endamoeba histolytica*. Moreover, their use has been "remarkably free of any side effects."[31]

KANTREX

INJECTION KANAMYCIN SULFATE INJECTION

INDICATIONS
Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives" genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and peritonitis.

DOSAGE: INTRAMUSCULAR ROUTE
Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

TOXICITY
When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

OTHER ROUTES OF ADMINISTRATION
KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

PRECAUTIONS
Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

SUPPLY
Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely)

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.
KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

CAPSULES (for local gastrointestinal therapy; not for systemic medication)

INDICATIONS AND DOSAGE
For preoperative bowel sterilization: 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

PRECAUTION
Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

SUPPLY
KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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COUGH ***promptly curbed*** by homarylamine—non-narcotic antitussive with the approximate potency of codeine.

INFECTION ***combated*** by three nonsystemic antibiotics—each active against common mouth and throat pathogens, all with relatively low sensitization potentials.

IRRITATION ***soothed*** by benzocaine—a topical anesthetic that promotes prolonged relief of inflamed or irritated tissues.

PENTAZETS® troches

Homarylamine · Bacitracin · Tyrothricin · Neomycin · Benzocaine

NEW PINEAPPLE FLAVOR Overwhelmingly selected by a taste panel.

Available to your patients on your prescription only.

DOSAGE: Three to five troches daily for three to five days.

SUPPLIED: Vials of 12.

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when the
rheumatic
disorder
is more
than salicylates
alone
can control...

MORE
HIGHLY INDIVIDUALIZED
THERAPY
FOR THE
RHEUMATIC
"IN-BETWEEN"

requir

int
steroid th

Aristo

wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
Ascorbic Acid	20 mg.

Supply: Bottles of 100 and 1,000.



Steroid-Analgesic Compound LEDERLE

Lederle

RLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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CLINICAL BRIEFS FOR MODERN PRACTICE



why should the urine be tested for sugar in acute cholecystitis?

The high incidence of pancreatic disease associated with pathologic conditions of the biliary tract indicates their close relationship. The appearance of glycosuria in acute cholecystitis points to involvement of the pancreas in the inflammatory process.

Source: Refresher Article: Biliary Tract Diseases, M. Times *85*:1081, 1957.

to help forewarn of pancreatic involvement...
and for reliable urine-sugar testing at any time

color-calibrated CLINITEST® BRAND Reagent Tablets

"...the most satisfactory method for home and office routine testing...."
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- STANDARDIZED READINGS...familiar blue-to-orange spectrum
- STANDARDIZED "PLUS" SYSTEM...covers entire clinical range
- STANDARDIZED SENSITIVITY...avoids insignificant trace reactions

consistently reliable results
day after day...
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NIAMID*

reduces pain in angina pectoris

NIAMID, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients...

- reduces frequency of anginal episodes
- diminishes severity of attacks
- decreases nitroglycerin requirements
- renews sense of well-being

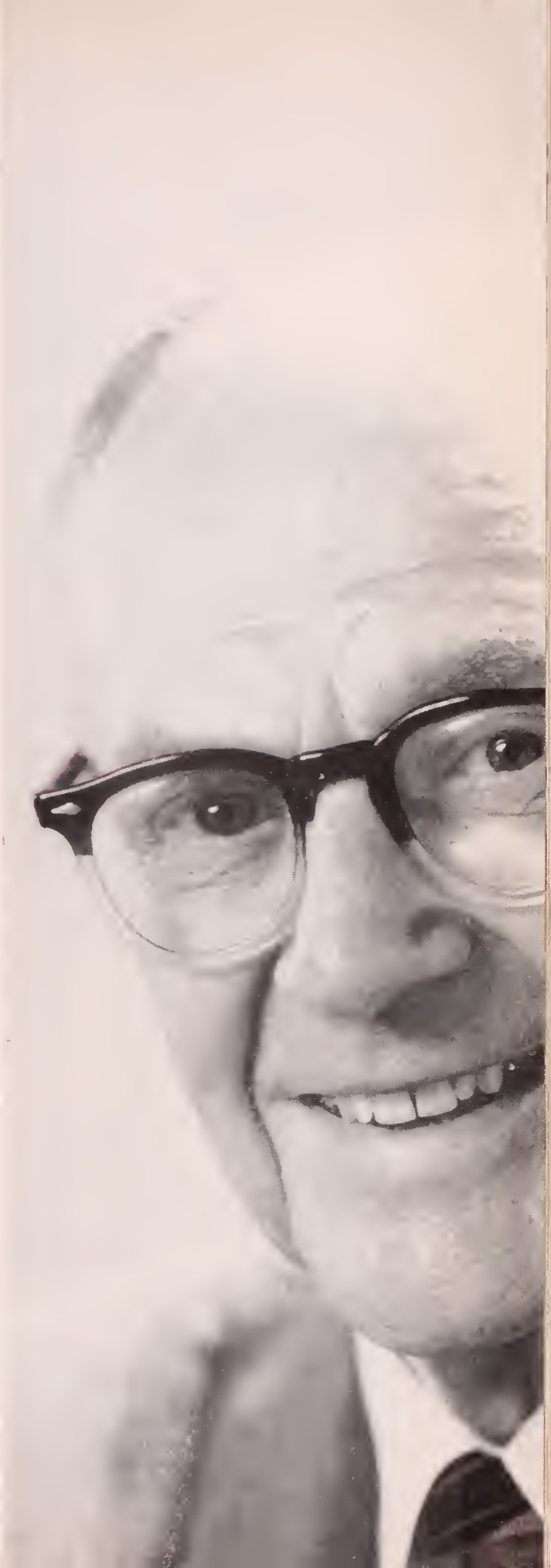
Note: Because of dramatic relief of symptoms and increased sense of well-being in anginal cases, it is advisable to caution the patient against overexertion.

DOSAGE: Start with 75 mg. of NIAMID daily in single or divided doses. After 2 weeks or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others within 7 to 14 days. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

A Professional Information Booklet giving detailed information on NIAMID *is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

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CLASSIC CONCEPTS

"Pure gastric juice, when taken directly out of the stomach of a healthy adult, unmixed with any other fluid, save a portion of the mucus of the stomach with which it is most commonly and perhaps always combined, is a clear, transparent fluid; inodorous; a little saltish, and very perceptibly acid."
—WILLIAM BEAUMONT, M.D., 1833



D MODERN THERAPY

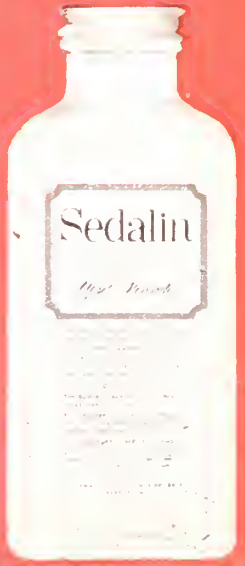
t, drink, and be merry...

Something like Sedalin has always been needed because of mankind's eternal wish to eat, drink, and be merry. Indeed, hyperacidity – generally the result of such overgence – has been and is so common among all peoples of the world that some of them have a virtue of necessity and turned the gaseous eructation into a compliment. But with Sedalin a compromise is no longer necessary, because this new antacid rapidly neutralizes 141.0 cc. 1 N hydrochloric acid with each tablespoonful. It maintains a desirable pH range that relieves patient of symptoms in the shortest possible time. And Sedalin is not constipating, contains no um and is not in any sense an astringent. Sedalin is exceptionally pleasing to the taste – so ing, in fact, that it can be taken indefinitely without loss of palatability. We think you will find patients pleased if you recommend this latest development in the search for the ideal antacid.

new Sedalin ntacid

Each tablespoonful (15 cc.) contains 5 grains of aluminum hydroxide, 3 grains of magnesium trisilicate, 4 grains of calcium carbonate and 4.5 grains of magnesium hydroxide, in a specially prepared demulcent base

Dosage: Adults—2 tablespoonfuls if needed repeat every half hour Children—6-10 years, 1 teaspoonful; 11-15 years, 2 teaspoonfuls; if needed repeat every half hour Supply 12 oz. bottles



Pharmaceuticals, Inc., New York 22, N. Y.



to prevent
the sequelae
of u.r.i. ...
and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

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Outstanding relief from torticollis and anxiety and tension states with

Trancopal®

THE FIRST TRUE "TRANQUILAXANT"

THE FIRST TRUE "TRANQUILAXANT"

Trancopal

potent MUSCLE RELAXANT
effective TRANQUILIZER

Indications:

Musculoskeletal[1]	Psychogenic[1]
Neck pain (torticollis, etc.)	Anxiety and tension states
Low back pain (lumbago, etc.)	Dysmenorrhea
Bursitis	Premenstrual tension
Rheumatoid arthritis	Asthma
Osteoarthritis	Angina pectoris
Disc syndrome	Alcoholism
Fibrositis	
Ankle sprain, tennis elbow, etc.	
Myositis	
Postoperative muscle spasm	

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours. The higher dosage is recommended for the treatment of patients in the acute stages of painful musculospastic conditions, and anxiety and tension states. Children (5 to 12 yrs.), 50 mg. three or four times daily.

Supply:

Trancopal Caplets®
100 mg. (peach colored, scored), bottles of 100.

New strength ▶ Trancopal Caplets
200 mg. (green colored, scored), bottles of 100.

"Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."[3]

". . . Trancopal is a most valuable drug for relieving tension, apprehension and various psychogenic states."[4]

1. Collective Study, Department of Medical Research, Winthrop Laboratories.
2. Lichtman, A. L. (N.Y. Polyclinic M. Sch. & Hosp.): Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.
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(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

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(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

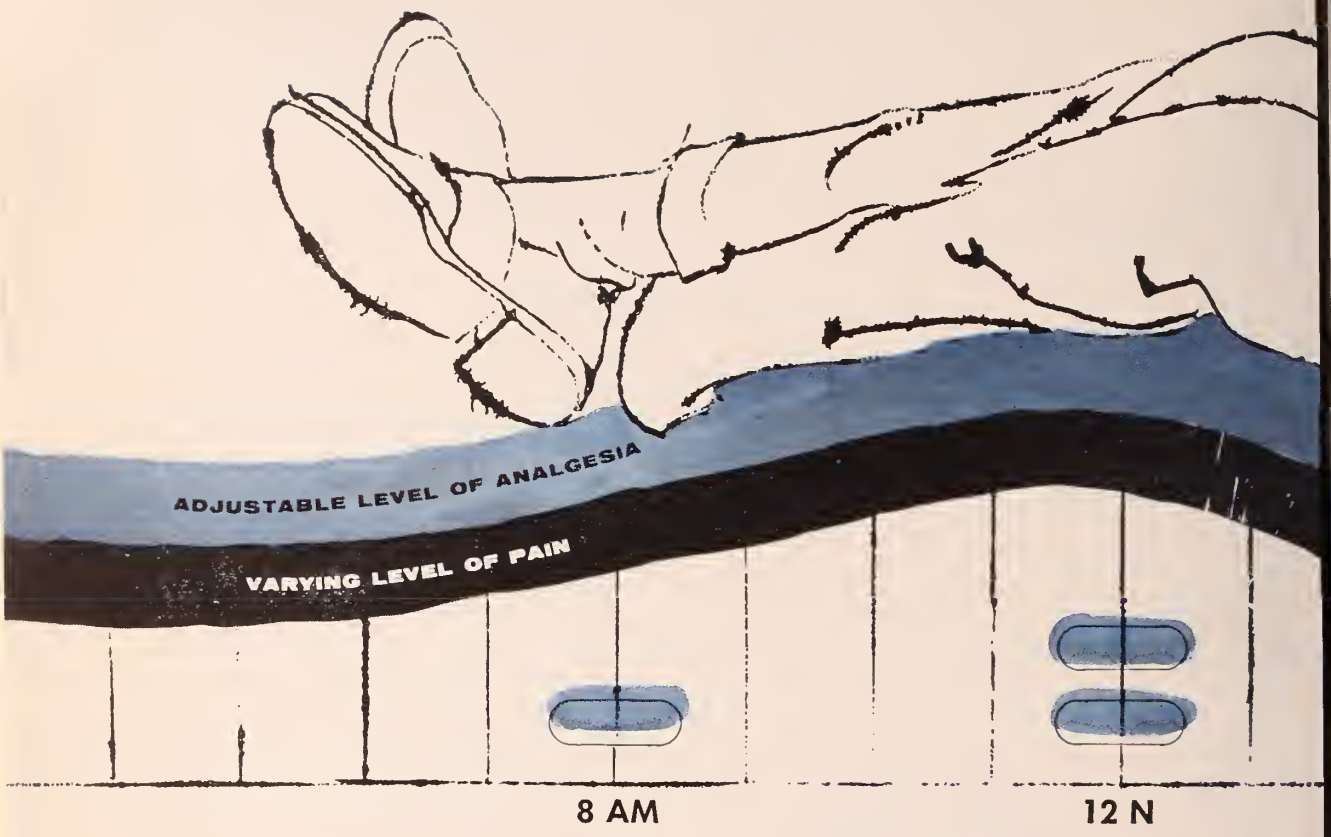
** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

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keep all patients* pain-free at all time

- with the proper potency to match pain intensi
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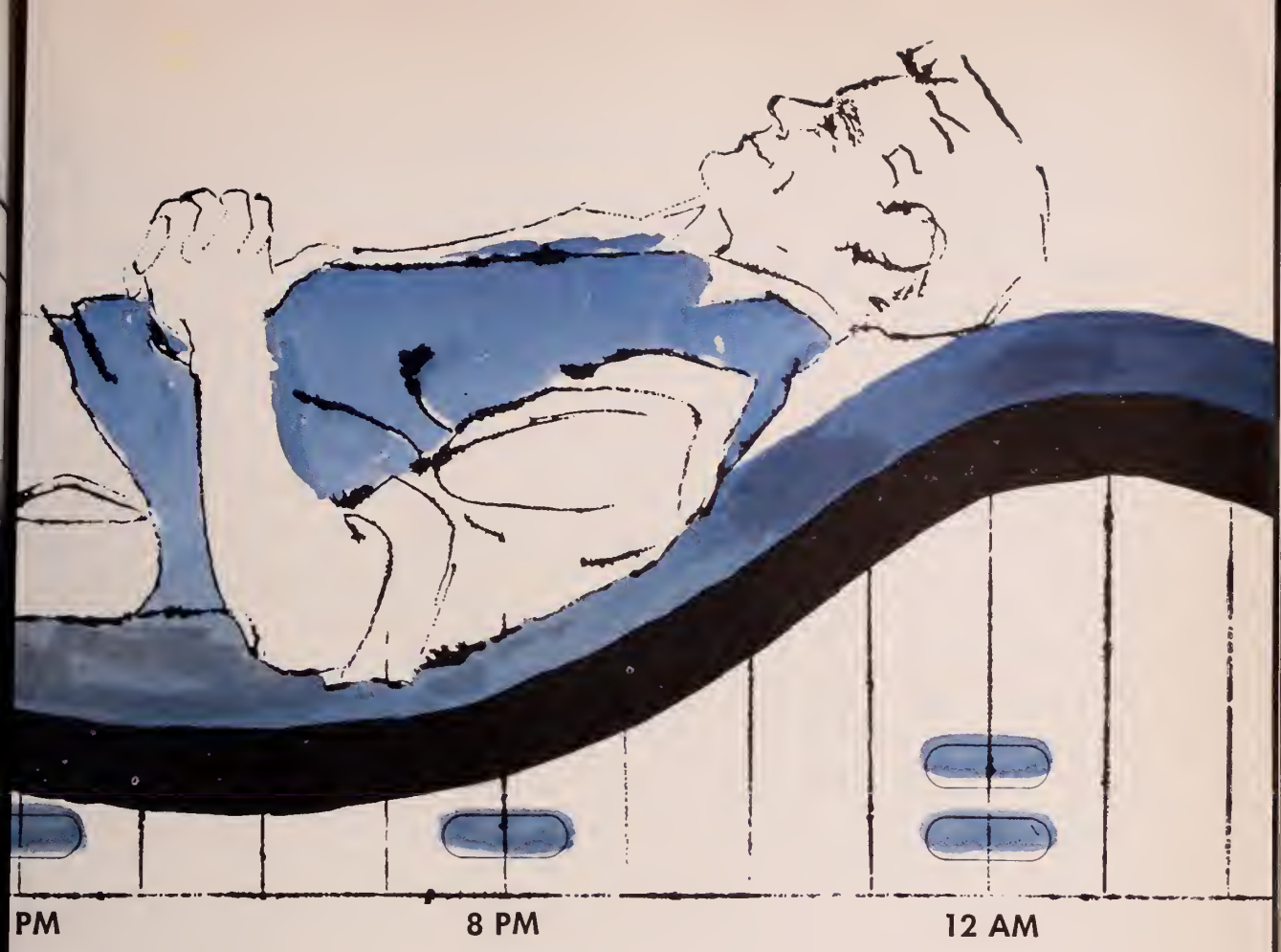
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Phenaphen®-with Codeine

*except those for whom recourse to morphine is inescapab

Robins A. H. ROBINS CO., INC., RICHMOND 20, VIRGIN

Ethical Pharmaceuticals of Merit since 1878



Phenaphen and Phenaphen with Codeine provide
a wide range of analgesia, plus complete dosage flexibility,
to match varying pain requirements.

Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

Phenaphen

Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

Phenacetin (3 gr.)	194.0 mg.
Acetylsalicylic acid (2½ gr.)	162.0 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

FOR THE ANXIETY TENSION PATIENT WHO IS ABOUT TO





Effective Anticholinergic-Antitensive

Relaxes the Spastic G. I. Tract

SED-TENS

TY-MED*

A unique timed-release principle incorporating the delayed acting therapeutic ingredients in an inert tablet matrix.

The release of medication is an erosive mechanical process independent of chemical media, therefore, not effected by gastro-intestinal environment.

DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital ..... 50 mg.
Homatropine Methylbromide 7.5 mg.

*LEMMON brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

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Sellersville, Pa.

For the first time

CONVENIENCE and ECONOMY

for that all-important first dose of broad-spectrum antibiotic therapy

New°

TERRAMYCIN®

brand of oxytetracycline

INTRAMUSCULAR SOLUTION



Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

...and for continued, compatible, coordinated therapy

COSA-TERRAMYCIN®

oxytetracycline with glucosamine

CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

Supply:

Terramycin Intramuscular Solution*
100 mg./2 cc. ampules
250 mg./2 cc. ampules

Cosa-Terramycin Capsules
125 mg. and 250 mg.

Cosa-Terramycin is also available as:
Cosa-Terramycin Oral Suspension — peach flavored, 125 mg./5 cc., 2 oz. bottle
Cosa-Terramycin Pediatric Drops — peach flavored, 5 mg./drop (100 mg./cc.), 10 cc. bottle with plastic calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

*Contains 2% Xylocaine® (lidocaine), trademark of Astra Pharmaceutical Products, Inc.

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The extended usefulness of TENTONE is readily apparent

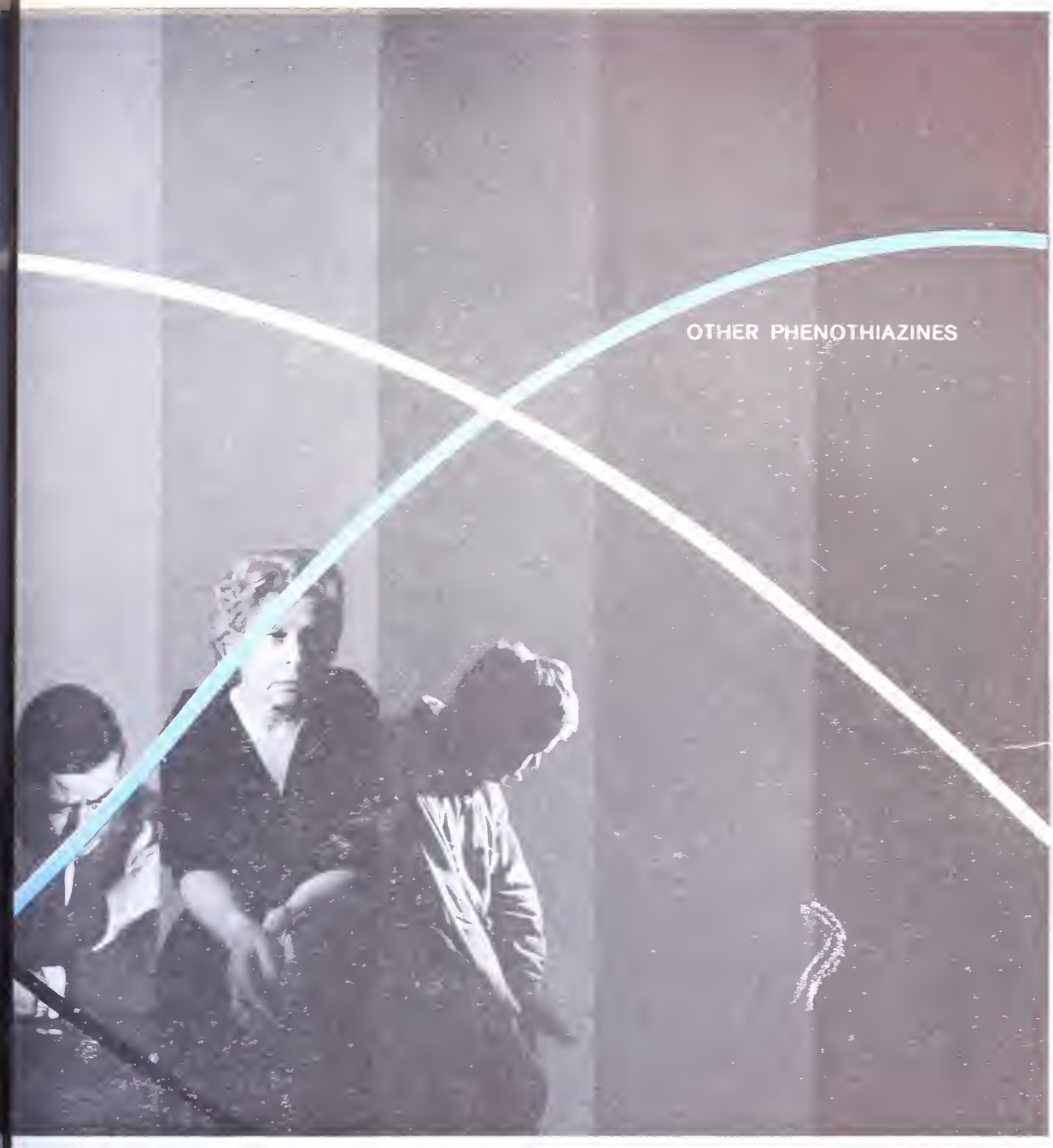
TENTONE® Methoxypromazine Maleate is a new, distinctive phenothiazine... highly active ...for general use in mild and moderate emotional and psychosomatic disorders.

TENTONE elicits a striking, positive calming response[1,2]...with marked reduction of psychic disorientation, and low risk of blood, liver or other organic toxicity and intolerance.[1-4]

TENTONE parallels the weaker ataractics in low incidence of side effects. Freedom from induced depression is apparently even greater.[5]

TENTONE provides a broadly adaptable dosage range (30 to 500 mg. daily) to permit maximum control in cases of varying severity.

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ge: Mild to moderate cases—average starting dose, one 10 mg. or one 25 mg. tablet or four times daily. *Moderate to severe*—average starting dose, one 50 mg. tablet times daily. *Supplied:* 10 mg., 25 mg., and 50 mg. tablets.

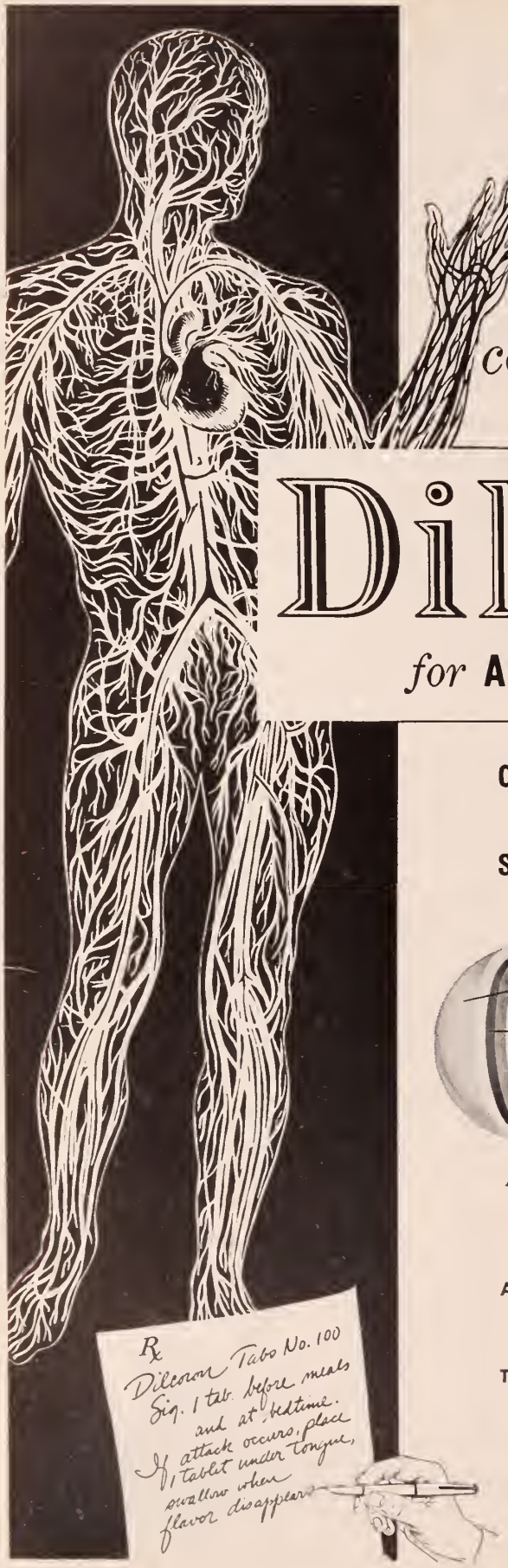
T., and Hoch, H.: Clinical report, Int. Psychiatry Congress. 2. Wilson, R. A., and Eldridge, R. M.: Clinical cited with permission. 3. Prigot, A.: Clinical report cited with permission. 4. Gerber, [illegible] 9 (April) 1959. 5. Turvey, S. L. C.: Clinical report cited with permission.

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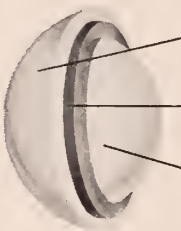
"flavor-timed" dual-action coronary vasodilator

Dilcoron®

for ANGINA PECTORIS

ORAL *(tablet swallowed whole)*
for dependable prophylaxis

SUBLINGUAL-ORAL
for immediate and sustained relief



Nitroglycerin
—0.4 mg. (1/150 grain)—acts quickly

Citrus "flavor-timer"
—signals patient when to swallow

Pentaerythritol tetranitrate
—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet on an empty stomach.

Bottles of 100.

Average prophylactic dose:
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(½ hour before meals and at bedtime).

Therapeutic dose:
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Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½
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Acetylsalicylic Acid	gr. 3½
Caffeine	gr. ½
Codeine Phosphate	gr. ⅛

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Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½
Caffeine	gr. ½
Codeine Phosphate	gr. ¼

No. 3

Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½
Caffeine	gr. ½
Codeine Phosphate	gr. ½

No. 4

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*Subject to Federal Narcotic Regulations

...providing the desired gradation of potencies for relief of varying intensities of pain

IN

simple headache
rheumatic conditions
arthralgias
myalgias
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earache
dysmenorrhea
neuralgia
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tension headache
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minor surgery
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trauma
organic disease
neoplasm
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colic
migraine
musculo-skeletal pains
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post-partum involution
fractures
synovitis bursitis

relief of pain
of all degrees of
severity up to
that which
requires morphine

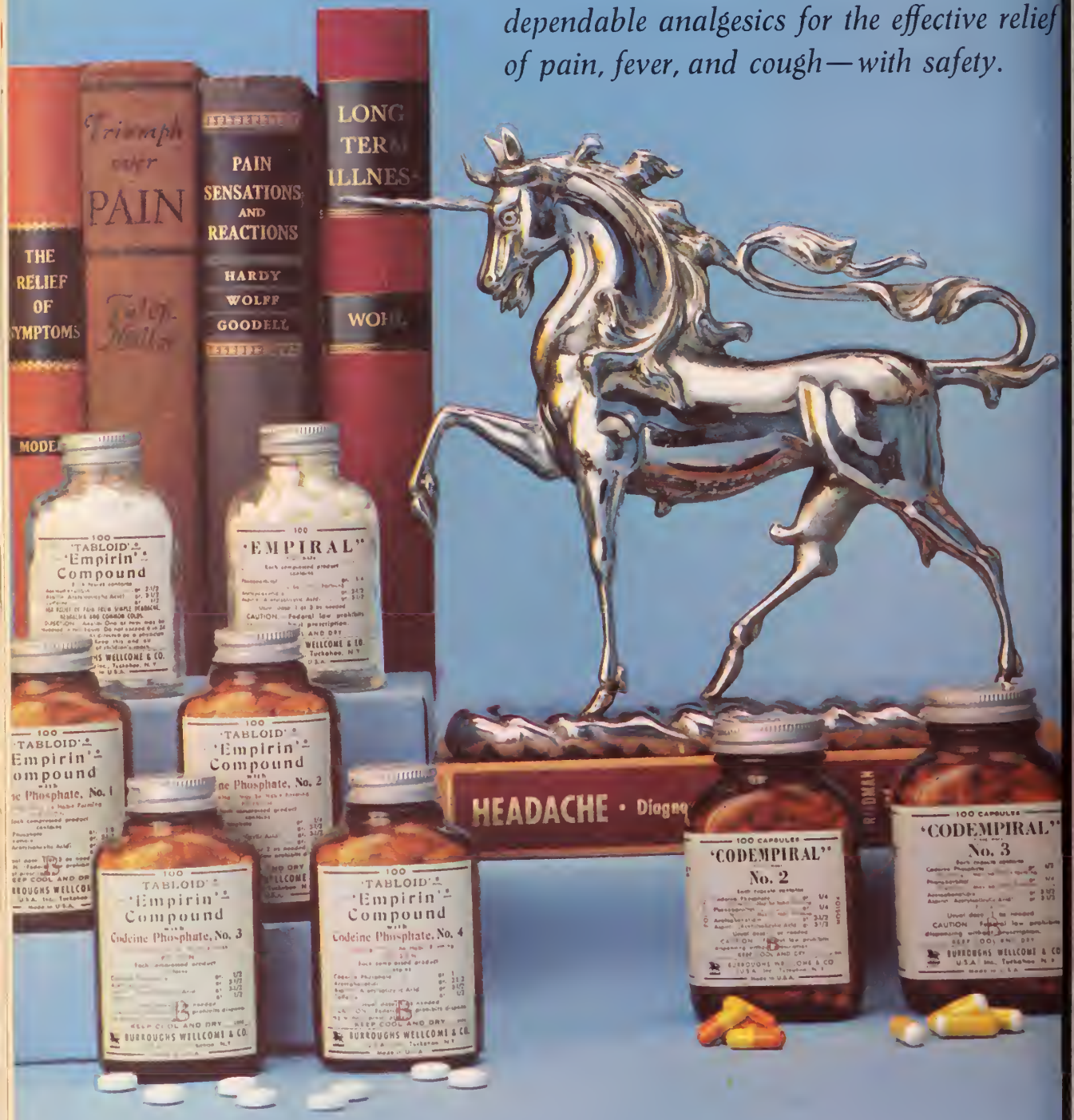
AND IN

fevers
dry,
unproductive coughs



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Tuckahoe, New York

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tablet stops morning sickness (you take it at bedtime)"



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More than 60,000,000 tablets prescribed and taken. Toxicity low, tolerance excellent. In bottles of 25 and 100. Usual dose: one tablet at bedtime; severe cases may require another on arising. See PDR, p. 779.

BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

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For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.*

Each cc. contains:
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

*Bibliography available on request.

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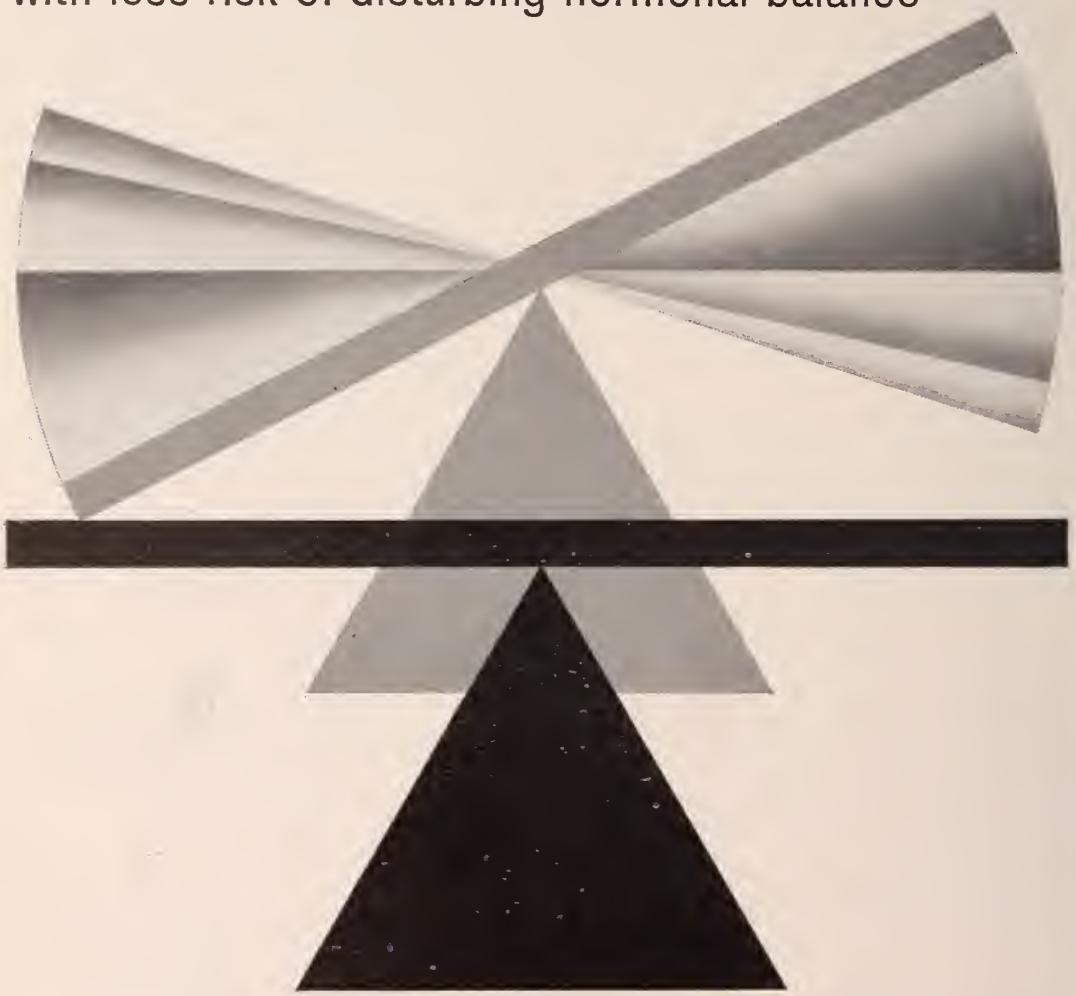
Effective relief in rheumatic disorders

Sterazolidin® capsules

prednisone-phenylbutazone Geigy

Geigy

with less risk of disturbing hormonal balance



In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

Repeatedly it has been shown that the addition of low dosage of Butazolidin sharply reduces hormone requirement.[1-4] Sterazolidin is a combination of prednisone (1.25 mg.) and Butazolidin (50 mg.) which provides, in the majority of cases, consistent relief at a stable uniform maintenance dosage significantly below the level at which serious hormonal imbalance is likely to occur.

Sterazolidin® (prednisone-phenylbutazone Geigy). Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg. and homatropine methylbromide 1.25 mg.

1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

03859



when upper respiratory congestion

is complicated by bacterial invaders

TRISULFAMINIC provides logical therapy

- for the patient ill with congestion and infection of the upper respiratory tract, as in purulent rhinitis, sinusitis, tonsillitis and otitis media, when caused by sulfa-susceptible bacteria;
- because secondary invasion by such bacteria so frequently follows the common cold.[1]

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Triaminic and triple sulfas are not only pharmacologically *compatible*, they are a therapeutically *logical* combination for upper respiratory infections: Triaminic for effective decongestant relief from rhinitis, rhinorrhea and sinusitis;[2] triple sulfas for well-established antibacterial action.

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TRIAMINIC WITH TRIPLE SULFAS

Available as TABLETS and SUSPENSION

Each easy-to-swallow Trisulfaminic Tablet or 5 ml. teaspoonful of Suspension provides:

Triaminic® .....25 mg.
(phenylpropanolamine HCl 12.5 mg.
pheniramine maleate ..... 6.25 mg.
pyrilamine maleate ..... 6.25 mg.)
Trisulfapyrimidines, U.S.P. .....0.5 Gm.

Dosage:

Adults—2 to 4 tablets or tsp. initially, followed by 2 tablets or tsp. every 4 to 6 hours until the patient has been afebrile 3 days. *Children 8 to 12* – 2 tablets or tsp. initially, followed by 1 tablet or tsp. every 6 hours. *Children under 8*—dosage according to weight.

The palatability, convenience and effectiveness of the Suspension make it especially suitable for children and for those older patients who prefer liquid medication.

References: 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

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There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the efficacy, potency and purity of Bayer Aspirin, the world's first aspirin.

And the same manufacturing skill, the same 106 ingredient and product tests, the same exclusive processes which contribute to the superiority of Bayer Aspirin set the standards of excellence for Bayer Aspirin for Children.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

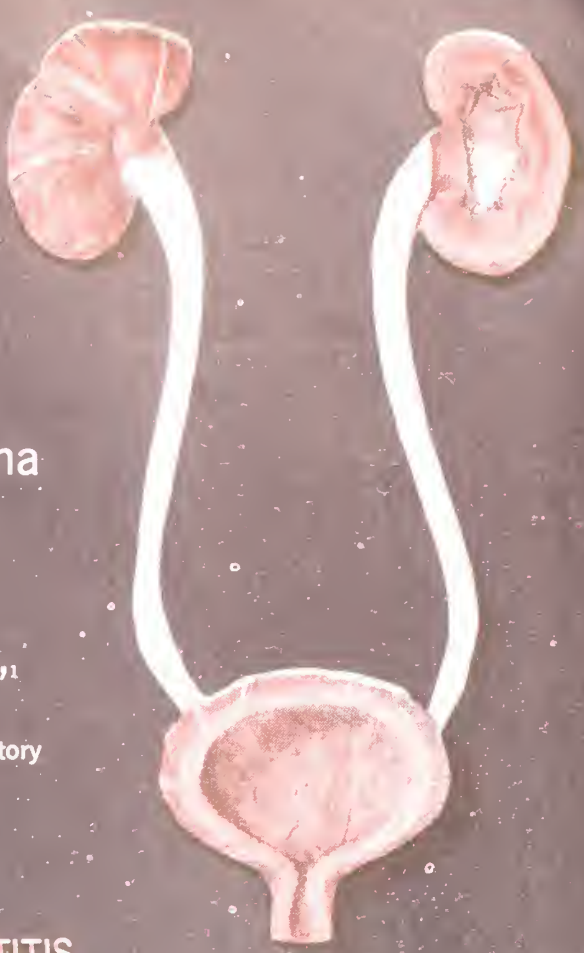
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"'Just a little case of cystitis' may actually have already involved the kidney parenchyma before the bladder became infected."[1]

"The first evidence of inflammatory disease of kidney or prostate often is vesical irritability."[2]



WHEN THE SYMPTOM IS CYSTITIS

FURADANTIN®

brand of nitrofurantoin

for rapid control of infection throughout the G. U. system

Rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria including organisms such as staphylococci, Proteus and certain strains of Pseudomonas, resistant to other agents ■ actively excreted by the tubule cells in addition to glomerular filtration ■ negligible development of bacterial resistance after 7 years of extensive clinical use ■ excellent tolerance—nontoxic to kidneys, liver and blood-forming organs ■ safe for long-term administration

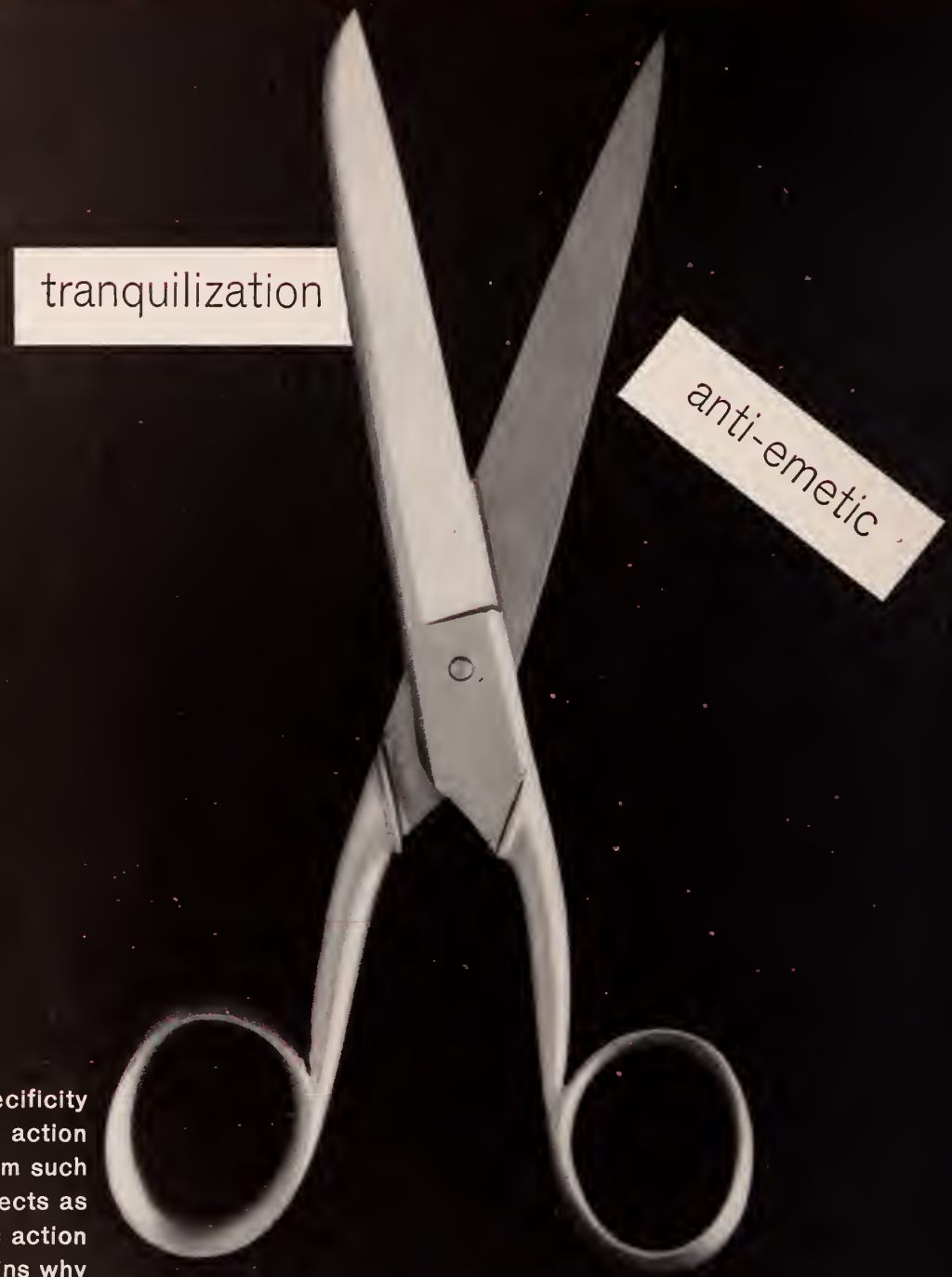
AVERAGE FURADANTIN ADULT DOSAGE: 100 mg. q.i.d. with meals and with food or milk on retiring. Supplied: Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Editorial: J.M.A. Georgia 46:433, 1957. 2. Colby, F. H.: Essential Urology, Baltimore, The Williams & Wilkins Co., 1953, p. 330.

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greater specificity of tranquilizing action —divorced from such "diffuse" effects as anti-emetic action —explains why

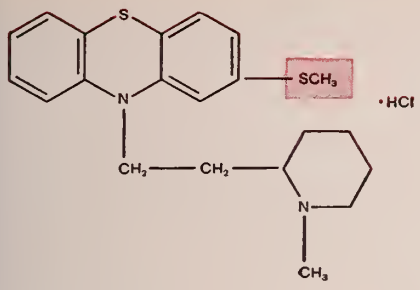
Mellaril®

THIORIDAZINE HCl

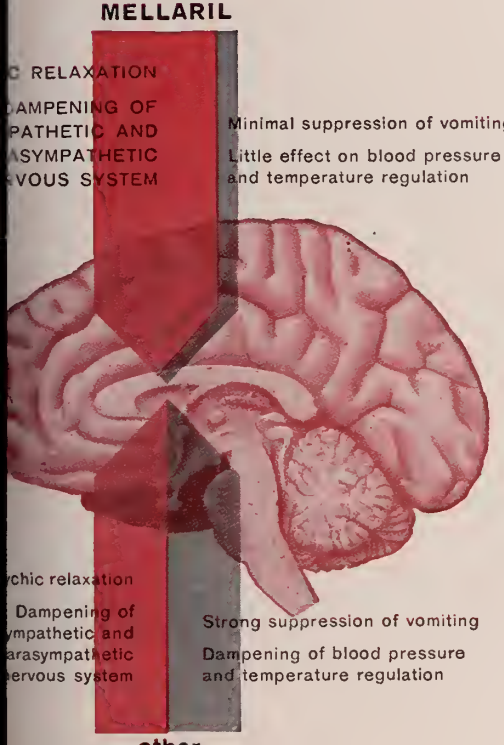
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines.... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

ew advance in tranquilization:
ater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical ($S\text{-}CH_3$) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	** TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
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Hospitalized	100 mg. t.i.d.	200-800 mg.
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, A. M.: Scientific Exhibit, American Academy
eral Practice, San Francisco, April 6-9, 1959

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Dosage: 125 or 250 mg. three times daily.

Supplied: In scored tablets of 125 and 250 mg. (200,000 and 400,000 units).

Also available

V-Cillin K, Pediatric: A taste treat for young patients. In bottles of 40 and 80 cc. Each 5-cc. teaspoonful provides 125 mg. of V-Cillin K.

V-Cillin K® Sulfa: Each tablet combines 125 mg. of V-Cillin K with 0.167 Gm. each of sulfadiazine, sulfamerazine, and sulfamethazine.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Labelling the Prescribed Drug

In line with the trend towards public education in medicine, is a suggestion that an identifying label be put on the prescribed drug bottle or box. So instead of acquiring a mysterious liquid or capsule the patient will know he is getting elixir of phenobarbital or meprobamate or amphetamine. This plan, it is suggested, will have five advantages. These are: (1) Another doctor will learn what his predecessor had prescribed, reducing the chance of error or duplication and lessening the likelihood of a sensitization response; and, incidentally reducing expense; (2) make it easier for the same physician to represcribe a satisfactory medication or avoid one that had had a bad effect; (3) make it safer, in an emergency, to prescribe an antidote; (4) make it easier for the travelling patient to get a good Rx refilled; and (5) promote reciprocal confidence between doctor and patient since the open labelling suggests good will, candor and complete faith—as well as avoiding any suggestion of magic or secrecy.

Which makes it sound as if all doctors ought to have pharmacists type the proper name on all prescription labels. There are, however, some disadvantages. It encourages self-prescription, particularly the sharing of medications by friends and neighbors who have similar symptoms. It leads to patients' swapping stories about drugs and their relative efficacy. It causes some to look up the drug in an encyclopedia or home doctor-book and get all sorts of quaint notions. Some medications are associated with particular ailments, some are supposed to be habit-forming, and some are alleged to be heroic medicaments used only for grave illness. Thus a knowledge of the name of the drug may be upsetting to the patient.

At one time, part of the doctor's magic was the incomprehensibility of the Rx. That little piece of paper was a passport to health, a ticket to recovery. The patient could derive satisfaction over a sonorous Latin designation

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like *Pilulae Hydragyri Chloridi Mitis Compositae* that would never have come about had the doctor written this in its English translation: "compound cathartic pills." There is surely more to the doctor-patient relationship than simple science; and that "something more" is a mystique that flourishes, like all mystiques, in an aura of the esoteric. Once the phrase "take your medicine" implied that it was bitter to take but good for your body and good for your soul. But to substitute a simple word like "aspirin" or a phrase like "vitamin B" for the one ineffable word, "medicine," is to bleach the color out of the relationship.

Frown and shudder, but take your medicine. Doctor knows best—or does he?

Make This Caller Welcome!

That veteran tuberculosis fighter—the Christmas Seal—is calling on you again this year. The annual Christmas Seal letter from the 21 county voluntary associations in New Jersey will soon make its way into homes all over our state. Your response to its message will help continue the battle against a constant menace to every individual and every home.

When the first Christmas Seal was introduced, 52 years ago, tuberculosis was indeed "the White Plague." Victims of tuberculosis were shunned. Little hope was extended to them. Scientific knowledge of the disease was at a minimum. Christmas Seal contributions over the last half century have helped to change that dismal picture.

Now the Christmas Seal with its familiar double-barred cross has become a symbol of hope. This year, Christmas Seal money will help 3000 voluntary associations assist 70,000 new victims of tuberculosis in this country. Tuberculin skin tests and chest x-rays will search out unsuspected cases, which, if left undiscovered, could infect others. Health education programs will help children and adults protect themselves from developing tuberculosis. Medical research will continue its efforts to overcome the disease wherever it develops.

Your 1959 Christmas Seal contribution helps to protect your community.

Give for Christmas Seals and use them.

The Merck Memorial Fund

For many years assistance has been offered to some medical students who need loans to complete school. However, on page 672 of this issue announcement is made of a unique variant of this principle. The Merck Memorial Fund will now offer loans to interns and residents. It is odd that so little attention has been paid previously to the need of this group. Actually interns and residents represent a safer investment than medical students since they are already doctors of medicine. We should all be grateful to the Merck Foundation for this enterprise; and be proud of the fact that Merck & Company call New Jersey their home.

NICHOLAS F. ALFANO, M.D.
Newark

Blue Shield Service Benefits*

THE FULL PAYMENT CONCEPT

Blue Shield fees are sometimes below the level which individual doctors fix for their own services. However, as shown in this article, there are compelling ethical and public relations reasons for adhering to the full payment concept.

THIS paper was motivated by a poll among physicians by The Medical Society of New Jersey, in regard to their willingness to accept or not accept a program for prepayment medical coverage of persons over 65 years of age. As proposed, this program, briefly, would be offered under Medical-Surgical Plan of New Jersey at reduced premium rates and payments for services would approximate an over-all reduction of 30 per cent as compared to the current fees provided by Blue Shield under its basic contract. Further, the proposed payments under such a program would be payments in full for eligible services rendered by Participating Physicians to a single subscriber whose income annually is under $2500 or under $3000 combined income of subscriber and covered spouse.

Results of the poll were overwhelmingly in favor of the program. However, the comments received from those physicians who indicated that they would not support the program as Participating Physicians, were of such nature as to prompt me to attempt to present a case in favor of the full payment principle which identifies and is exclusive to most Blue Shield plans among all others in the prepayment health insurance field.

The words "service benefits" have been the most controversial words in the practice of medicine. The concept has been the subject of more argument than any other aspect of the economic side of medical practice.

Full payment is what we are talking about when we say "service benefits." It might be clearer to all of our members if we use the simple term *Full Payment* instead of the ambiguous "service benefits" which apparently have different meanings for each person who hears them.

Why should "service benefits" or *Full Payment* have aroused so much feeling among the profession?

Full Payment is controversial in medicine because when we talk about service benefits we are talking about money—physicians' money—payment for physicians' professional services. Then too, we are also talking about fixed fees for services. If there are any two subjects which will arouse the physician's interest they are payment for his services and the question of fixed fees. It, therefore, is not remarkable that they have become the subject of so much controversy since Full Payment is intimately concerned with both.

Most of the discussions of Full Payment have been highly emotional and in many cases based upon an isolated unfortunate personal experience. Some physicians have not even waited for the experience but with active imagination have conjured up all sorts of tragedies which would befall the practice of medi-

*Delivered at meeting of the Essex County Medical Society, April 9, 1959. Dr. Alfano is the Medical Director of N. J. Blue Shield.

cine if Full Payment, even on the limited basis currently in use in Blue Shield, should become an accepted principle. It is paradoxical that seldom have the opponents of Full Payment considered the extent of the disaster which will befall medical practice if the failure to provide Full Payment to the groups which deserve it, influenced Congress to have the Government decree by legislation, what the physician was unwilling to provide voluntarily.

It is unlikely that anything which may be said on behalf of the Full Payment or "service benefits" principle will ever convince a considerable number of physicians. Neither does it seem likely that Blue Shield plans will ever satisfactorily answer every physician's individual complaints regarding the inequities which will occasionally result. Nevertheless, it seems worthwhile for those of us who regard the Full Payment principle as essential to the continued independence of medical practice to continue to show our colleagues the soundness of our viewpoint.

The views expressed are mine and not necessarily those of Medical-Surgical Plan or other Blue Shield plans. I do *not* believe that the Full Payment principle should be applied to all levels of income. Such a situation would produce mediocrity in medical practice by removing any incentive for a physician to excel in a particular field of medicine and be properly remunerated for his skill. However, Full Payment must be made available to all who have lower levels of income where anticipated medical care expenditures cannot be met by the individual without sacrificing other necessities for a desirable standard of living.

THERE are only three statements that need to be understood and accepted by any practicing physician in order for him to be willing to give his support to a Full Payment program.

First, Full Payment is the only practical manner in which the traditions of the medical profession can be applied to the practical considerations of the business of running an insuring company.

Second, Full Payment is primarily for the welfare of the patient whose interest medicine has always been proud to protect, and

Third, Full Payment is the only means by which medicine in the long run can be maintained as a voluntary profession.

If these statements are factual, every practicing physician would be as morally and ethically obliged to support the Full Payment concept with his best efforts as he does his County Medical Society, or he would wish to support it simply as a matter of prime self-interest. Let us see how well we can prove to you the truth of these statements. The first statement, "Full Payment is the only practical manner in which the traditions of the medical profession can be applied to the practical considerations of the business of running an insurance company." The traditions of the medical profession have always insisted that the welfare of the patient be the first consideration of the practicing physician. When these principles were initiated there was no such thing as medical care insurance but these ethical principles have not been significantly modified despite the tremendous growth of voluntary prepaid medical care. These principles are accepted as a basic obligation by every ethical physician in medical practice. The circumstance that money is made available through an insurance corporation for the payment of physicians' services when they are required, should not make the practicing physician any less dedicated to the fulfillment of his ethical responsibilities in the tradition of medicine. His prime interest is in the welfare of his patient.

The low-income patient must have the professional services whether or not he has funds. This is medicine's pledge to him. Why should not adequate funds provided by an insuring company be acceptable as full reimbursement by the physician particularly when the physician himself arranges the fee schedules as he does in Blue Shield? Half a loaf is better than none. Service benefits—Full Payments being made today by the better Blue Shield Plans are far from being only a "half loaf." This is a second logical, direct and practical application of the principles of medical ethics to the insurance of medical care for the lower income groups.

All insuring companies provide certain dollar amounts which will be paid should the risk

occur for which liability had been assumed. Such payments are called indemnities since like all forms of commercial insurance they indemnify, that is to say, "compensate" or "make restitution for," the loss resulting from the occurrence of the risk. As far as I know there has been no over-all objection to indemnity voluntary health insurance by the medical profession although, I believe, on a specific claim basis (particularly in the compensation and third party negligence fields), there is frequently a wide difference of opinion between the insurer and physician as to the value of the latter's professional services.

To return to the over-all view, if each practicing physician developed a schedule of fees which he would accept as full payment for the services which he renders his patient and if the insurance carrier could sell such a contract to his patients, the physician would, presumably, then be willing to accept the indemnity fee as full payment for his services. The transaction would have no such inflammatory title as "service benefits." It would be indemnity insurance and the physician would be pleased with the situation. Let us examine for a moment the sources of his satisfaction. The professional services which he renders will be covered by insurance. He, therefore, may anticipate 100 per cent collections. Next he is going to receive for his professional services the amount of money which he thinks is his due since he himself set the fees in the schedule. Lastly, he knows his patient will be pleased because the patient will not have to spend any of his own funds, obviously every patient's idea of medical Utopia.

Let us compare this optimal situation with the practical functions of a Blue Shield "service benefit" or Full Payment program. They differ in only one respect and again the consideration is money. In the first instance the physician sets up his own fee schedule himself, while under Blue Shield plans it is arranged and accepted by himself and a large group of his fellow practicing physicians rather than by himself alone. The only obstacle that the non-participating physician finds to supporting a Full Payment program is that, to do so he must relinquish his right to construct his own individual fee schedule for every professional service he renders. The non-participating physician is not willing to relinquish this right even to his fellow physicians and work with them to construct the schedule, although he has just as much influence on each of them in the determination of dollar amounts of the Blue Shield Full Payment schedule. In New Jersey there are some 7,000 practicing physicians. Over 5,700 physicians participate in Medical-Surgical Plan and provide Full Payment services in accordance with the provisions of the contract. We can hardly solve the problem for our non-participating physicians by having one schedule for 5,700 participating physicians and 1,300 additional individual schedules for each of the non-participating physicians.

How does the low income patient feel about not having "service benefit"—Full Payment from the non-participating physician? The low income patient is just as interested as is his physician in fully insuring himself against loss should certain risks occur. When you and I have an automobile accident we would like the insurance company to pay in full for the damages. The low income patient feels the same way about his medical care. We do not like deductible collision insurance. We have to; but then the repair of cars is a trade and does not require the same consideration as a profession such as medicine.

The low income patient feels he should be able to buy complete protection against the hazards of illness. It seems reasonable that he should be able to do so. Why is he unable to? Because, except for those who are Participating Physicians in the medically sponsored Blue Shield plans, physicians are unwilling to tell anyone the dollar amount they will accept as full fees. The patient, therefore, buys coverage with the highest medical fee payments he can afford in the hope that the indemnity he receives will be adequate to meet the physician's bill in full. More often than not, it does not do so.

The patient then finds it hard to understand what has happened to all the solicitude that he understood the medical profession has always felt for his welfare. *If the medical pro-*

fession is to adhere to its ethical position that service to the patient is the first motivation for practice, then ultimately it must accept a reasonable fee as full payment for the services rendered to low income patients. The dollar amount of any fee is not the significant factor in the operation of an insuring company. The stability of the dollar amount and its acceptance by all physicians are the pertinent criteria.

The physician may conceivably, but rarely, be able to make a sound case for the adverse effects which Full Payment to lower income groups would have on the financial return of his practice. By doing so, however, he is arguing against the ethics of his profession which require that the welfare of his patient —not the financial return of his practice—be his first consideration. I have yet to hear a sound argument against Full Payment in terms of the welfare of the low income patient.

THE last statement, "Full Payment is the only means by which medicine in the long run will be maintained as a voluntary profession," does not require extensive documentation to demonstrate its truth.

The variable fees of the past and the present were and are based on the ability of the patient to pay. In a day when a large segment of the population was unable to pay medical costs, variable fees were a reasonable means of effecting an average payment for all patients. The vast majority of our population can now pay the costs of Blue Shield membership charges if a contract is available to them. In view of this circumstance, justification of variable fees must become more and more difficult.

There is an easy tendency to assume that any fee which is fixed is necessarily incorrect. This is far from the truth. One of the major reasons the costs of physicians' services (although increased) have not kept pace with the rising costs of living is because more physicians have adhered for many years to their own particular pattern of fees. These fees, of course, are fixed but they are fixed by the physician himself, and therefore, we may presume that he feels they are correct. Once again, we return to the view that the correctness of a fixed fee depends upon who is doing the fixing.

Medical fees in the future for the vast majority of our population must be fixed. It is only on that basis that it will be possible for insurers to provide coverage and for patients to meet medical costs. It is impracticable to advise a patient that he should budget from his income to meet the costs of his medical care unless you are willing to tell him what he may expect these costs to be.

Under Full Payment—Blue Shield Service Benefit Plans, practicing physicians are the ones who fix the fees for themselves. This is as it should be. The practicing physician has nothing to say about the fees provided in commercial insurance contracts. If we eventually come to a governmentally controlled medical care program, medical fees (in keeping with familiar bureaucratic policy) will probably be arrived at by the one person who can be found in government who knows least about the practice of medicine, certainly not by the practicing physicians who will provide the professional services.

I have tried to summarize by four principles the present situation as far as the practicing physician is concerned.

1. If, in the future, the physician expects to be paid, the insurance coverage must do it.
2. If insurance is to do it, medical fees must be stabilized.
3. If medical fees are to be stabilized, practicing physicians ought to do it.
4. If practicing physicians are going to do it, each physician must surrender some of his individuality on behalf of the profession as a whole.

These statements represent a sound simplification of our complex problem, a bedrock foundation for future medical practice that cannot be circumvented, no matter how much we might wish to do so. There is only one remaining consideration in this discussion of Full Payment. If Full Payment—(service benefits) is not the answer to the problem of meeting the medical care costs for low income groups—what is?

Certainly the answer does not lie with indemnity insurance!

Medical costs must not be—"all the traffic

can bear." They must be reasonable and proper for the services rendered. The public is aware that, in some instances, indemnity insurance may represent a liability rather than an asset when their physician comes to make out his bill.

Blue Shield Service Benefits—Full Payment Plans represent the most forward step which the medical profession has yet taken to make it possible for patients to have the best medical care at a price they can afford to pay. No indemnity insurance plan can argue that its benefits are equivalent or better than a Blue Shield Full Payment Plan. Blue Shield Service Benefits—Full Payment contracts possess the quality (if I may paraphrase the slogan of which a leading pharmaceutical firm has long been proud) "the priceless ingredient, the honor and integrity of the physician." Full Payment contracts of Blue Shield plans *guarantee* Full Payment coverage—this no indemnity plan can do.

THE American public, the patients, and not the medical profession will ultimately decide whether the practice of medicine continues to be voluntary or becomes subsidized and controlled. Unless it is possible for a majority of our people to insure themselves against medical care costs for significant medical treatment, the final decision of the public can be easily anticipated, and the medical profession will not like it.

I conclude by quoting two prominent practicing physicians who have no direct association with the Blue Shield organization.

Dr. Charles H. Bradford, a Boston surgeon, in an article in the April 3, 1958 issue of the New England Journal of Medicine, stated: "On the one side, we find ourselves threatened by State and Federal programs already operating on a large scale and eagerly seeking still further enlargement. On the other side, we contemplate the ugly possibility of domination by pressure groups such as labor unions or dictation from commercial interests. In front of us we face the inescapable and insurmountable wall of rising costs, in which the doctors' fees play only an insignificant part as compared to the staggering costs of hospitalization. Behind us we hear the hue and cry of an increasingly hostile public opinion, unleashed and led on by demagogues who clamor for the priceless gifts of life and death at bargain rates and at the taxpayers' expense.

"One of the few constructive steps taken by the medical profession in the last twenty years," continued Dr. Bradford, "has been the adoption of Blue Shield. It may represent one of our few hopes for survival as a self-determining profession."

Dr. Bradford concluded his article with the following admonition. "We must stop focusing our thoughts childishly on income levels and fee schedules; we must stop bickering and yammering. We must grasp the larger significance of the splendid organization that we have built up in the last 20 years. We must stand behind it in its major decisions—not for selfish gain, but to share with the public a mutual service and benefit. In this way, and in no other, can the medical profession preserve its time-honored status as an altruistic body of men, free from the sordid controls of politics or commerce, devoting itself wholeheartedly to scientific and humanitarian tasks."

Dr. Elmer Hess, a past President of the A.M.A., aptly sums up the role of Blue Shield and Blue Cross in this country's health problems today in the following statement: "Without Blue Shield and Blue Cross our hospitals and ourselves would be hard put to render the services that these two organizations have made possible. Since we have accepted the insurance principle, many patients who previously would be non-paying patients have had their bills at least partially paid and I am rather intolerant of the physician who is not a participating member of Blue Shield and who complains when Blue Shield pays the patient and not him directly. I also am intolerant of the physician who in defense of his attitude in not being a participating member says with a loud voice 'nobody is going to tell me what to charge.' I am outspoken enough to say the physician who takes such an attitude is primarily interested not in service, but in money. Today's professional freedom to be a private practitioner of medicine instead of a slave to government, is due solely to Blue Shield—the physicians' answer to socialized medicine."

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Safer Diuresis*

Chlorothiazide by Discontinuous Administration

In this miniature monograph the authors review the efficacy of the various modern diuretics.

Diuresis may be enhanced, either by accelerating the glomerular filtration rate or by depressing the tubular reabsorption of electrolytes and water. From a practical viewpoint, the most valuable diuretics are those that depress the tubular reabsorption of electrolytes and water. The ideal diuretic should meet the following criteria: (1) Maximum potency, (2) Minimal toxicity and side reactions, (3) Maintenance of effectiveness with prolonged administration (absence of tachyphylaxis), (4) Ready availability and ease of administration, preferably oral.

Experimental studies[2] on renal hemodynamic effects of chlorothiazide show no significant change in glomerular filtration rate or renal blood flow. The demonstrated inhibition of carbonic anhydrase *in vitro* does not appear to be of any significance *in vivo,* in explaining its mode of action.[5]

Following the oral administration of chlorothiazide, there is a marked excretion of sodium and chlorides. The ratio of sodium to chlorides is almost one. The excretion of potassium is about 50 per cent or less than sodium[2] and is considerably smaller than that produced by carbonic anhydrase inhibitors.[3] At these same therapeutic levels of chlorothiazide, an increased bicarbonate excretion is found, though not large enough to alter the urinary pH. This might, however, occur at high dosage levels. At therapeutic levels, bicarbonate excretion is about one quarter that of chlorides. Chlorothiazide diuresis, therefore, is most probably induced by the inhibition of the tubular reabsorption of water and electrolytes.[2] Following a single oral dose, chlorothiazide produces effects within two hours, lasting from six to twelve hours.[2,3,4]

Intravenous administration of chlorothiazide produces the same electrolyte effects which follow oral administration, except that the effect is earlier in onset and shorter in duration, indicating perhaps a less effective result.[2]

Chlorothiazide is most useful in the management of congestive heart failure of all etiologies, whether acute or chronic, in hospitalized or ambulatory patients. It sometimes proves effective in patients who have become refractory to other diuretic agents. Furthermore, subjects who fail to respond to chlorothiazide are often unresponsive to other diuretic therapy.[7] However, cardiac arrhythmias have been observed after prolonged and continuous administration of chlorothiazide, usually without electrocardiographic signs of hypokalemia, which are readily reversed by the temporary interruption of the therapy or the administration of potassium chloride.[7]

Because potassium deficit increases the in-

*Read April 29, 1959 before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey. This work is from the Medical Service at the Newark Beth Israel Hospital where Dr. Tami is a resident.

cidence and severity of digitalis intoxication, some authors[13] have advised a reduction in the maintenance dose of digitalis in patients treated with chlorothiazide over prolonged periods. An interrupted method of administration of chlorothiazide (for instance, five days out of seven) in patients in long-term treatment is also recommended.[12]

Other conditions in which chlorothiazide has been used include: chronic cor pulmonale,[8] portal cirrhosis with ascites,[8] the nephrotic syndrome,[9] Kimmelstiel-Wilson syndrome, toxemia of pregnancy, pre-menstrual tension, hypothyroidism, ascites or edema due to malignant tumors and the fluid retention and hypertension which may follow or accompany the administration of corticosteroids. In such cases, the administration of chlorothiazide may aggravate the potassium loss produced by some steroid, so that prophylactic administration of potassium chlorides is advisable in patients receiving combined chlorothiazide and steroid therapy.

It is not within our scope to discuss the anti-hypertensive effect of chlorothiazide.

A comparative study on the potency of chlorothiazide and mercurial diuretics Salyrgan® (mersalyl), tested clinically by the measured amount of diuresis produced in edematous patients, the majority of whom were in congestive heart failure, was reported by Bayliss *et al.*[4] Eleven edematous patients were studied, ten of whom had congestive heart failure of different etiologies and had shown little or no response to bi-weekly injections of 2 cubic centimeters of mersalyl. This refractory condition could not be attributed to any electrolyte imbalance, such as hypochloremic alkalosis or hyponatremia. They were put on oral chlorothiazide, and five of these patients had a good response, with complete clearing of the edema. Four of these mersalyl-resistant cases gave a fair response, in the sense that the edema did not clear completely; or it quickly recurred when the sodium intake or the physical activity was increased. Two patients did not respond to either drug, either singly or in combination.

Another attempt to evaluate the comparative diuretic effect of chlorothiazide and mercurial diuretics is reported by Davies and Evans.[11] Oral chlorothiazide was given in one Gram doses twice a day to 20 patients with congestive heart failure. In seventeen of these, parenteral mercurial diuretics were also given (mersalyl) at varying intervals. Chlorothiazide produced a good therapeutic effect in all cases, the diuretic response being equal to that following parenteral diuretics.

Other studies[2-10] comparing the potency of chlorothiazide with that of mercurial diuretics demonstrated that the natriuretic effect of approximately 1000 milligrams of chlorothiazide, given orally, equals that of a cubic centimeter of Mercuhydrin®, administered parenterally.

It was our feeling that if chlorothiazide is as effective orally as parenterally administered mercurials, it might best be administered at single and more widely separated intervals. This is common practice with all mercurial diuretics. In this way, the complications of hypokalemia could be minimized, and still an effective diuresis could be conveniently induced.

Therefore, a two part study was begun. First, a calibration of the efficacy of chlorothiazide was studied by comparing the diuretic response following the administration of varying doses of chlorothiazide to the response after a mercurial diuretic in the same patient.

Second, the effectiveness of the diuresis induced by intermittent individual doses of chlorothiazide rather than a daily maintenance program was observed.

METHOD AND MATERIALS

All patients studied demonstrated obvious edema fluid. Twenty-three were in congestive heart failure; two were edematous secondary to portal hypertension; one had ascitic fluid due to peritoneal metastases. Daily morning weight observations were recorded. All cardiacs were fully digitalized and all the patients were held on modified or complete bed rest with salt restricted diets. When the weights stabilized at a constant level, the following procedures were carried out.

In 14 patients, a comparison of the response to varying doses of chlorothiazide with 2 milliliters of mercaptomerin given intramuscularly was per-

formed. Chlorothiazide was used in doses of 0.5 Gram, 1.0 Gram, 1.5 Grams and 2.0 Grams at an interval of at least three days apart in the same individual. The weight change due to the subsequent diuresis was compared with the weight change following the parenteral administration of mercaptomerin given at least one time to each subject. The schedule of administration of diuretics was varied and randomized so that some subjects received the smallest dose of chlorothiazide first, others, the largest, while others received the mercurial diuretics first. The order of administration of the varying doses of chlorothiazide was varied, as well. Diuretic efficacy was measured only by weight changes.

A second group of 14 patients whose weights were stabilized as described previously, were given 1.0 Gram of chlorothiazide in single or divided doses. The weight change was compared in the same patient with the weight change following administration of 2 cubic centimeters of mercaptomerin, again given intramuscularly. Each subject received at least one dose of each diuretic and in the majority of cases multiple observations were recorded.

RESULTS

Table 1 summarizes the results in calibrating the diuretic efficacy of varying doses of chlorothiazide. It was quickly apparent that the diuresis after 0.5 Gram of chlorothiazide was unpredictable and grossly inadequate when compared with the larger doses. Moreover, the one Gram dose gave a maximal diuresis averaging 2.4 pounds. That was essentially the same as the 1.5 Gram or 2 Gram doses, which were 1.8 pounds and 1.4 pounds respectively. The variation in weight loss with each dose was well within the limits of variation of this type of experiment. This diuresis, maximal with 1.0 Gram of chlorothiazide, moreover, was unrelated to the single or divided method of administration of chlorothiazide, so that the total dosage could be given at once in the morning with a maximum effect.

TABLE 1.

CALIBRATION OF THE MINIMAL ORALLY EFFECTIVE DOSE OF CHLOROTHIAZIDE

Dose of Chlorothiazide in Grams	No. of Trials	Amount of Average Weight Loss in Pounds
0.5	3	0.7
1.0	11	2.4
1.5	10	1.8
2.0	8	1.4

The potency of chlorothiazide is comparable with that of mercurial agents. This is shown not only by the magnitude of the diuresis, but also by the fact that only a very few cases were found in our series which responded to one type of diuretic but not to the other. One patient who was unresponsive to chlorothiazide did not show any response to mercurial diuretics either. Three patients responded to mercaptomerin and not to chlorothiazide while five patients responded to chlorothiazide and not to mercaptomerin.

Table 2 summarizes our findings of the efficacy of the one Gram dose of chlorothiazide as an intermittently administered oral diuretic in 26 patients, as compared with the weight loss induced in the same patients by intramuscular administration of 2 milliliters of mercaptomerin. The total diuretic activity of both agents was similar in each subject. Usually, when one was effective, both were; and if the patient was unresponsive to one, the other usually failed. Average weight loss after administration of mercurial was 1.9 pounds. Average weight loss after using chlorothiazide was 1.75 pounds. The diuresis following chlorothiazide was usually later in onset by six to twelve hours but lasted somewhat longer. No symptoms of hypokalemia occurred in any of these subjects.

TABLE 2.

COMPARISON OF THE DIURETIC RESPONSE OF CHLOROTHIAZIDE ORALLY AND MERCAPTOMERIN INTRAMUSCULARLY

Diuretic	No. of Trials	Amount of Average Weight Loss in Pounds
Mercaptomerin: (2 ml. intramuscularly)	26	1.9
Chlorothiazide: (1.0 gm. per os)	26	1.8

Figure 1 describes the typical responses seen. The top curve represents the patient who responded well to chlorothiazide and to mercaptomerin; the middle line shows the patient whose initial response to diuretics was good, but who then resisted the effect of both drugs. The bottom curve indicates the patient who was refractory to both diuretics.

COMMENT

Our experiment clearly shows that the diuretic response which can be anticipated following the intermittent oral administration of chlorothiazide approximates that due to parenterally given mercurial diuretics, also given in intermittent fashion. Though the onset of diuresis appears to be delayed for several hours (compared with the more rapid response to intramuscular mercurials) the final results are approximately the same. All of the requirements previously described as pertinent to an *ideal* diuretic agent are more closely approximated by chlorothiazide than by mercurials.

For example, the ease of administration which is obviously common to all oral drugs is self-explanatory. Also, the potency of the drug was maintained easily after prolonged administration if diuresis was possible with either the mercurial or chlorothiazide. None of the patients studied showed any significant refractoriness, except for the one who was refractory to mercurials too, considering that a more marked response is naturally to be anticipated during the early course of the treatment, when the fluid retention is more conspicuous. It may be of interest to point out that, to the contrary, early drug resistance has been considered [14] a characteristic of the response to other oral diuretic agents, classically, carbonic anhydrase inhibitors.

No toxic side reaction was observed at any time. We did not observe symptoms or signs of digitalis toxicity or signs of hypokalemia. In this respect, we have to emphasize again our *method* of administration of the drug, namely in intermittent fashion rather than on consecutive days. This accounts for the lack of side effect even when chlorothiazide was given over prolonged periods of time. We were not able to dissociate, in the review of the literature,[15] the hypokalemic effects from the prolonged daily administration of chlorothiazide. While showing that the intermittent administration of chlorothiazide is effective in promoting a considerable weight loss, our study also indicates the safety of such a system even when, as in our cases, no potassium supplement was given. In acutely ill patients, where an immediate response is imperative or oral administration is impossible, mercurial diuretics are still the drugs of choice.

DOSAGE

Optimum response can be anticipated with one Gram of chlorothiazide. Smaller doses are considerably less effective. Larger ones produce no better response, while the hazards of side effects are potentially increased. The optimum dose of one Gram may be given either in a single or in divided doses without any noticeable difference in diuretic effect.

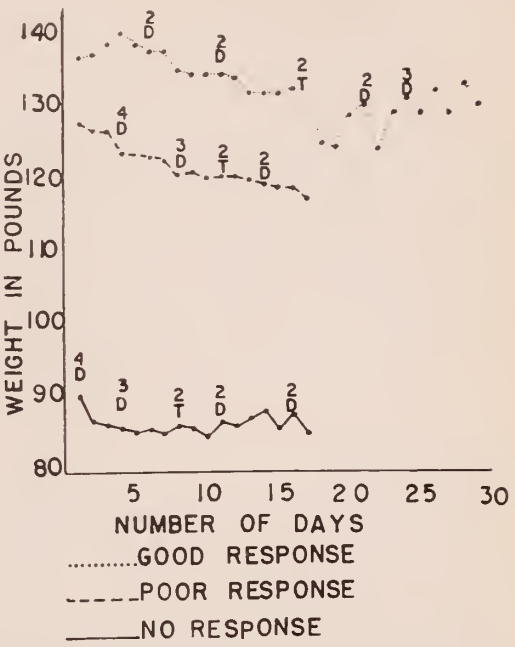


Figure 1. The varying diuretic responses on comparing orally administered chlorothiazide and intramuscularly administered mercaptomerin.

SUMMARY

1. The diuretic efficacy of varying doses of orally administered chlorothiazide was compared with the diuretic effect of mercaptomerin given intramuscularly in 23 patients with congestive heart failure and three patients with fluid retention of other etiologies.

2. The optimally effective oral dose of chlorothiazide was one Gram given either as a single dose or divided in two doses over a twelve-hour period. Higher doses were no more effective. Intermittent doses of one Gram of chlorothiazide were as effective in inducing a diuresis in patients with fluid retention as an intermittently administered mercurial diuretic, given in a 2 milliliter dose intramuscularly.

3. It is suggested that a more reasonable and safe approach to the use of orally administered chlorothiazide would be to give one Gram once or twice weekly as has been the practice with parenterally administered mercurial diuretics.

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A full listing of bibliographic citations appears in the authors' reprints.

Joseph P. Donnelly, M.D.

Jersey City

Prevention of Fetal Trauma*

Although fetal trauma has decreased there is still no reason for smugness. In this hard-hitting article Dr. Donnelly shows what can be done about it.

The incidence of fetal trauma has decreased during the last two decades in all the leading obstetrical clinics. This has been pointed out by Dr. Nesbitt and many other writers on perinatal mortality. Unfortunately this is not true in the majority of hospitals in this or other states. To indicate that there is still a great deal of traumatic obstetrics being done in New Jersey, let me remind you that Dr. Zindwer, Chief of the Bureau of Maternal and Child Health of the State Board of Health and also Dr. John Preece, Chairman of the Maternal Welfare Committee of the State Society have both informed me that in the last five years hemorrhage is still the principal cause of maternal death in New Jersey. This is sufficient evidence that "strong arm" obstetrics is still being done in this state because a large number of these fatal hemorrhages occurred after traumatic deliveries and the babies were also lost.

The four operations which are notorious for a high incidence of postpartum hemorrhage and also of fetal trauma are—version and extraction, high forceps, difficult mid forceps delivery, and breech extraction. These four procedures are the principal traumatic causes of intracranial hemorrhage in any series of reported fetal deaths.

I will discuss, for the record, a few reasons why these operations should be re-evaluated and then a few words about what methods must be used to limit this type of delivery.

*Read before the Section on Obstetrics and Gynecology, The Medical Society of New Jersey, April 28, 1959, Atlantic City, N. J.

VERSION AND EXTRACTION

Version and Extraction—that potent method of rupturing uteri and inflicting fetal trauma should be relegated to the museum along with the Voorhees bag, the quill, the cervical dilator and the bougie.

As has been previously reported, there were eight ruptures of the uterus following 347 versions and extractions with 5 maternal deaths at the Margaret Hague Hospital between 1931 and 1941. This is an incidence of one rupture to every 47 versions.

Because of this experience and also because the fetal loss following version in these cases was about 15 per cent, it was decided that version and extraction, in our clinic at least, was a very dangerous procedure. Since that time version and extraction have practically been eliminated except for the delivery of the second twin. However, in 1956 Dr. Kurtz reviewed 500 consecutive twin deliveries at the Margaret Hague and while noting there is a much higher fetal loss in the second twin than in the first twin, he also noted that this loss seemed to be definitely increased when version and extraction were done on the second twin. We, therefore, no longer allow the house staff to do versions and extractions on the second twin for so-called "teaching purposes." If the

second twin presents by vertex, rupture of the membranes during a contraction with the head fitted over the inlet is the easier way to deliver the second baby. This is less traumatic to the fetus than elective version. If uterine contractions have ceased after the delivery of the first twin then either a Pitocin® infusion is started or a minim of Pitocin® is given intramuscularly and as the patient has a uterine contraction, the head is fitted over the inlet and the membranes ruptured.

HIGH FORCEPS DELIVERY

THE ease and safety with which a cesarean section can be done today has certainly eliminated the need for high forceps delivery. If a vertex will not engage after the cervix is fully dilated it is much less traumatic to the mother and baby to do a cesarean section than forcefully to pull the head into and through the pelvis with forceps. Few people start out to do a high forceps delivery today; but I know that many cases which they believe will be mid forceps deliveries turn out to be high forceps as the forceps are applied. Caput can be down to, or even below, the spines and still the biparietal diameter of the head may be above the inlet. Even in patients with prolonged rupture of the membranes or a possible uterine infection, an extraperitoneal section or even a low flap section or a cesarean section with hysterectomy is still less traumatic to mother and baby than a high forceps delivery. *There is no place for high forceps in present day obstetrics.*

MID FORCEPS

WHILE there is some danger to the fetus from a mid forceps delivery, I believe that when this operation is carried out by trained personnel or under the supervision of trained personnel that there should be no increase in the neo-natal mortality due to trauma. Dr. Robert Cosgrove and Dr. Weaver in 1957 reviewed 1000 consecutive mid forceps deliveries at the Margaret Hague. The incidence of mid forceps deliveries was 2 per cent which was approximately one-half of the cesarean section rate of the hospital. These operations were performed by 96 different operators. Seventy of the 96 were resident physicians who did the forceps deliveries under supervision. The neo-natal loss in this group was 2.8 per cent. Five cases showed evidence of intracranial hemorrhage at autopsy. This peri-natal death rate of 2.8 per cent for the 1000 mid forceps deliveries was lower than the peri-natal mortality of the clinic of 3.5 per cent, but, of course, the incidence of prematurity in the mid forceps cases was insignificant. However, the 2.8 per cent neo-natal mortality is a valid figure as 7 per cent of the cases showed evidence of fetal distress at the time the operation was done. Four of the five babies who showed intracranial hemorrhage at autopsy were delivered by the house staff. Mid forceps deliveries can be done without trauma to the mother or child if the following rules are followed:

1. The essential prerequisites for forceps application must all be present—*first*, a deeply engaged head; *second*—a fully dilated and retracted cervix; *third*—rupture of the membranes; *fourth*—no definite disproportion.

2. The mid forceps delivery is to be done by or under the direct supervision of an experienced operator.

3. The operation should be undertaken soon after progress has ceased. Prolonged second stages of labor cause anoxia in the fetus and make it more susceptible to intracranial hemorrhage when forceps are applied. Judicious use of Pitocin® for the stimulation of labor when contractions have become ineffectual due to uterine inertia will often bring about further progress and will frequently change a mid forceps operation into an easy low forceps, or even a spontaneous delivery. However, if the patient is having good uterine contractions all multiparas should be delivered within two hours after full dilatation of the cervix has occurred; all primiparas in approximately three hours. Waiting for 6 or 8 hours in the second stage and then applying forceps to a child which is already suffering from anoxia due to prolonged labor will definitely bring about an increased incidence of intracranial hemorrhage. If labor is tumultuous it may be necessary to shorten the

time before the baby is delivered by forceps or cesarean section. If you allow the head to pound away on the perineum for 5 to 6 hours before delivery is accomplished you will have an increased incidence of fetal trauma and intracranial hemorrhage.

I think the anesthesia given for a mid forceps delivery is important in preventing fetal trauma. It is generally agreed that the anoxic baby is more susceptible to intracranial hemorrhage, therefore, I believe spinal or caudal anesthesia is the anesthetic of choice in a mid forceps delivery. The mother is given oxygen by mask during the procedure so that the baby is well oxygenated. In addition, there is excellent relaxation of the perineal muscles which also aids in the delivery.

If the above suggestions are followed I believe mid forceps deliveries can be done with minimal fetal trauma.

BREECH EXTRACTION

While the prognosis for the mother is good in breech presentation, there is definitely an increased risk for the child. The higher the presenting part at the beginning of the breech extraction, the higher the fetal mortality. Tentorial tears and intracranial hemorrhage are inherent in breech presentation whether delivered spontaneously or by breech extraction. In addition in breech extraction, fracture of the clavicle, humerus, or even the femur can occur. Paralysis of the arm from pressure on brachial plexus is also noted. Rupture of the liver and spleen have also been reported. For these reasons, breech extraction can be a very hazardous procedure for the baby. Even in the premature baby, breech extraction can be fraught with danger to the infant. The head of the premature baby is disproportionately large and it may become incarcerated after the easy delivery of the buttocks and chest.

Cesarean section in breech presentation in elderly primigravidas at term is frequently the procedure of choice; and in the diabetic primigravida it is mandatory.

An arrested breech will almost always be more safely managed by cesarean section than by breech extraction.

TRANSVERSE PRESENTATION

Transverse presentation is a serious complication of labor and frequently a cause of fetal trauma. Its early recognition is important. The malpresentation can be diagnosed by careful abdominal examination in the majority of cases. We have all been fooled, however, and it is now a rule of the hospital that as soon as a footling breech is diagnosed the patient must be taken to the delivery room and a careful vaginal examination must be done. In many cases the diagnosis of a footling is then correctly made as a hand or shoulder presentation.

When transverse presentation is diagnosed early in labor, cesarean section is the method of choice. It is always the method of choice in primigravidae.

Occasionally in a rapidly dilating multipara where the cervix is at or near complete dilatation when the patient is first examined, the two feet may be brought down and the patient allowed to deliver spontaneously. However, the rapid delivery of this type case by version and immediate extraction can be accomplished only if the cervix is completely dilated. Even under ideal conditions it is a dangerous procedure. This is particularly true with oversize babies and also with prematures where the head is much larger proportionately than the buttocks and the shoulders.

May I repeat, cesarean section is the method of choice in transverse presentation, as it is less traumatic to the mother and the fetus.

WHO DOES THEM?

As I look at this audience today I realize that it is composed almost entirely of trained obstetricians or general practitioners whose principal interest is in obstetrics. The fact that all of you are fairly regular attendants at this and other obstetrical meetings throughout the year indicates that you know as well as I or Dr. Schretzmann, or Dr. Greeley or Dr. Nesbitt, the dangers of traumatic obstetrical procedures such as version, high forceps and breech extraction.

You will tell me that you avoid these procedures but you must admit that these traumatic procedures are still being done in your county and possibly in your hospital.

Is this any business of yours or mine? I think so. What can you do about it? Two things: first see to it that the Tissue Committee of your hospital makes the hospital staff get autopsies on all perinatal deaths and that these deaths are discussed at a regular monthly meeting. Secondly, see to it that the rules for obstetrical consultation in your hospital are reevaluated and then strictly enforced.

I know of several hospitals in this state where a part of the staff have what they call "B" privileges. This entitles these staff members to do all types of vaginal deliveries, including high forceps, mid forceps, breech extractions and versions; but they are not permitted to do cesarean sections. Is this, do you think, an obstetrical rule to protect the mothers and babies? Or is it an open invitation to mayhem? This type of obstetrical rule means that obstetrical consultation is looked for after the damage is done. In other words, the obstetrician will be called in to repair a lacerated cervix or to do a hysterectomy on a traumatically ruptured uterus. It would certainly be better not to have a rule than to have a rule of this type. I would suggest that all cases of abnormal pregnancy or any abnormal parturition should require obstetrical consultation and if the consultant obstetrician believes that the other doctor is capable of carrying out the procedure he should give him permission to do so, for that particular case. Abnormal parturition certainly includes any type of forceps, breech extraction, cesarean section, oxytocin inductions or stimulations, postpartum hemorrhage, cervical laceration and other operative procedures. Abnormal pregnancy which would also require consultation would be toxemias, anteparium and interpartum bleeding, cardiacs, diabetics, intraparium fetal death and infection. This, of course, means that the attending obstetrician may be called upon to give many gratuitous consultations. At times after getting the history of the case (and if he knows the practitioner is capable) he can give his permission to proceed; but it should be done on a case to case basis and not as a blanket privilege. This also means that the general practitioner must get used to calling consultations before he undertakes any abnormal parturition instead of after he gets into a difficulty. The general practitioner should certainly be encouraged to continue to be the family doctor and he should be allowed to take care of the mother of the family when she becomes pregnant and when she is admitted to the hospital, as long as he realizes his limitations and quickly gets consultation when abnormal situations arise.

THE OBSTETRICIAN'S RESPONSIBILITY

THE attending obstetrician is given the privilege, the authority and the responsibility of supervising the obstetrical service. He must use this authority to raise the level of obstetrical care in the community. He must never use this authority for his personal advantage. You tell me such a scheme is Utopia and it can't work. It is already working in many large hospitals in this state but unfortunately not in the majority of them. For the past 28 years I have seen such a plan in operation at the Margaret Hague Hospital where it was instituted by Dr. Sam Cosgrove in 1931. We have always had 150 to 200 practitioners on our staff who have the right to take care of normal obstetrics and normal pregnancies. They obey the rules. The practitioners as a whole appreciate the assistance given them. They realize that not only the mother and the baby but also their reputations are protected. A practitioner can be given permission to do a low forceps delivery if it is known he is capable of doing it but only after it is definitely determined that the forceps he is going to do is a low forceps delivery. Practitioners as well as the obstetrician realize that the patient who has been showing a little caput for 2 to 3 hours without delivery is not usually an elective low forceps delivery. The practitioners appreciate the assistance they get. The obstetricians and practitioners have a reciprocal respect for each other.

CONCLUSIONS

IF WE are carefully to analyze and prevent fetal trauma, it is essential that the following two rules be adopted by every hospital staff in the state.

1. Tissue Committees should see to it that autopsies are obtained on all perinatal deaths. If a doctor is unable to get an autopsy he should file a formal report with the tissue committee stating why he was unsuccessful. The case histories and the autopsy reports on all perinatal deaths should be reviewed at a regular monthly staff meeting.

2. All cases of abnormal parturition or abnormal pregnancy should require obstetrical consultations. Permission for operative obstetrics or to care for an abnormal pregnancy should be granted to non-obstetricians only after consultation on each individual case. The enforcement of these rules will curtail maternal and fetal trauma.

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4. Kurtz, G. R., Loftus, J. B. and Keating, W. J.: Obst. and Gyn., 6:370 (1955).
5. Zindwer, R.: Public Health News, 1958.

Cigarettes and Cancer

Doll* reports two studies on lung cancer and cigarette smoking and reviews hypotheses suggested to account for the results. Data on 187,783 men who died of lung cancer in the United States have been compared with data on 24,354 men who died of the same disease in Great Britain. The first group was followed up for nearly 4 years, and the second for more than 6 years. The mortality rates among all the men, including nonsmokers and smokers, were about 10 times greater than the rates among nonsmokers, and the *mortality rates among heavy cigarette smokers were about* 20 *to* 30 *times greater than those among nonsmokers.* The mortality rates among cigarette smokers were substantially greater than the rates among other types of smokers, and the mortality rates among mixed smokers of cigarettes and other types of tobacco were intermediate. The mortality rate was lower when smoking had been stopped for 1 to 10 years, and was substantially lower when smoking had been stopped for 10 years or more.

The author concludes that the association of lung cancer and cigarette smoking is not an artifact resulting from the method of study. It does not necessarily follow that smoking causes the disease. It is suggested (1) that smoking determines the site of cancer appearance, (2) that the precancerous condition induces smoking, and (3) that smoking and cancer result from a common factor (heredity, alcohol). The principal observations which have been cited as incompatible with the theory that cigarette smoking is a causal factor in the production of the disease are (1) the increasing disparity in smoking habits, (2) the disproportion between the mortality from lung cancer and the cigarette consumption in different countries, and (3) the conflict of evidence with regard to the apparent effect of inhaling. It seems reasonable to conclude that none of the data provide a compelling reason for abandoning the hypothesis of causality.

*Doll, Albert, Page 1876 of Aug. 8 (1959) Journal of The American Medical Association.

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Parasitic Diarrheas*

Incidence, Diagnosis, and Treatment

Parasitic infestations have not seized the medical image the way bacterial infections have. Nonetheless, as pointed out here, parasitic infestation of the intestinal tract is a major health problem.

Stoll,[1] in his now historic article, "This Wormy World," estimated that there are now throughout the world some 70 million intestinal tapeworm, 85 million intestinal fluke and nearly 1.75 billion intestinal roundworm infections. Add to these figures the estimated incidence of intestinal protozoal infections at over 450 million, with amebiasis leading the parade with 300 million, and the importance of parasitic infections becomes apparent. See Table 1.

The importance of constant consideration of a possible parasitic etiology in cases of diarrhea is also apparent when one realizes that *more than two-thirds of the parasites infecting man reside in the intestinal tract*, that about 16 per cent of the population of this country has or has had trichinosis, that about 5 per cent of Americans harbor Endameba histolytica and that the asymptomatic carrier of this organism may be responsible for a tragic epidemic. Radke [2] showed the importance of parasitologic studies in a review of 68 autopsy reports of patients who died of amebiasis; the clinical diagnosis had been wrong in 52 cases —which amounts to 76 per cent! Kleitsch [3] studied 100 consecutive cases of amebiasis in whom the outstanding symptoms were abdominal pain and diarrhea; 17 had been diagnosed as having some form of non-specific colitis, 5 were treated for hemorrhoids because of rectal bleeding, and 3 had tumors complicated by amebiasis. In 1950, Towse, Berberian, and

TABLE 1.

PREVALENCE OF INTESTINAL PARASITIC DISEASES (Estimated)*

Disease	N. America	The World
Protozoa		
Amebiasis	10,000,000	300,000,000
Giardiasis	20,000,000	150,000,000
Balantidiasis	100	100,000
Total about	30,000,000	450,000,000
Roundworms		
Enterobiasis	18,000,000	200,000,000
Trichinosis	21,000,000	28,000,000
Ascariasis	3,000,000	650,000,000
Hookworm infections	1,500,000	450,000,000
Trichuriasis	400,000	350,000,000
Strongyloidiasis	400,000	35,000,000
Total about	44,000,000	1,713,000,000
Tapeworms		
Hymenolepiasis	100,000	20,000,000
Taeniasis saginata	100,000	39,000,000
Taeniasis solium	1,000	2,500,000
Diphyllobothriasis	1,000	10,000,000
Total about	200,000	70,000,000
Fasciolopsiasis	●	10,000,000
Schistosomiasis		
japonicum	●●	46,000,000
mansoni	●●	29,000,000
Total about	??	85,000,000
Grand Total about	75,000,000	2,300,000,000

* Modified from Stoll: "This Wormy World," J. Parasit. 33:1 (1947).

● Represents less than 100,000 cases.

●● Represents probably more than 150,000 cases.

1. Stoll, N. R.: This Wormy World. Jour. Parasit., 33:1 (1947).

2. Radke, R. A.: Amebiasis. Gastroenterology, 21:525 (1952).

3. Kleitsch, W. P.: Amebiasis in Surgical Patients. Am. Jour. Surg., 79:450 (1950).

*Read at the 193rd Annual Meeting, The Medical Society of New Jersey, Section on Gastroenterology and Proctology, Atlantic City, April 29, 1959.

Dennis[4] reported an incidence of over 13 per cent of amebic infections in 350 individuals studied in central New York State, where sanitary conditions were considered "conventional" or "superior." In 1957, Jeska and Gentzkow[5] reported that more than 22 per cent of the enteric specimens examined by the laboratories of the Pennsylvania Department of Health in the preceding five years were positive for parasites; also, that the Philadelphia Department of Health Laboratory reported that among the immigrant workers 63 per cent of the specimens were positive.

The recent immigration of large numbers of Puerto Ricans, infected with single or multiple parasitic species, has resulted in the simultaneous immigration of large numbers of parasitic diseases. Our returned veterans bring back parasitic infections from endemic areas. Air travel permits parasitic infections to be brought in by tourists and other travelers even before the incubation period of many parasites can be completed.

All of this means that we North Americans are not immune to or free from parasitic infections; that we have in our midst many parasitoses capable of producing acute and chronic diarrheas; that the recognition and treatment of intestinal parasitic infections are important responsibilities of every physician.

DIAGNOSIS

THE important pathogenic intestinal parasites of man, the group in which they belong, their normal habitat, and the diseases which they produce are shown in Table 2.

The unsanitary disposal of human excreta, a polluted water supply, the house fly, and close contact of individuals in crowded institutions are the most important modes of transmission of these organisms. The diarrheas which they produce usually cannot be diagnosed on clinical grounds alone. The range of clinical findings is wide and depends on the severity of the infection, the type and location of the organisms, and the general condition of the host. In addition to the diarrhea, there may be systemic, emotional, allergic, or other manifestations which may direct attention away from a possible parasitic etiology. History, symptoms, and physical findings cannot be taken as definite evidence for or against parasitic infection. Anemia, leucocytosis, and eosinophilia may suggest infection or infestation but should not be considered diagnostic. Serologic and skin tests, and culture methods are not always available or reliable. Therefore, the diagnosis of a parasitic diarrhea depends on the laboratory demonstration of the causative organisms in fecal (or other) specimens.

Since stool examinations are indicated in all except transitory diarrheas, a good laboratory with competent personnel is essential. In addition to a good laboratory, there must be a knowledge on the part of the physician of what material should be collected for submission to the laboratory, the proper methods of collection and preservation, and the number and sequence of specimens to be submitted.

Material to be examined: This should consist of normally passed stools; stools obtained after purgation or enema; material obtained by swabbing or aspiration, or by biopsy of mucosal ulcers; material obtained by aspiration or biopsy of extra-intestinal lesions or by duodenal intubation; material obtained by smears of perianal skin.

The mention of purgation stools is not an error. Patients with chronic diarrheas may be seen during remissions when formed or constipated stools occur. A mild saline laxative, or enema, will frequently cause expulsion of parasites from the higher portion of the bowel. This procedure is especially valuable in the diagnosis of amebiasis.

Methods of collection: Since parasitological examination entails a search for both protozoa and worms, specimens must be collected and preserved in such a manner as to ensure preservation of both types of parasites. Two methods of stool collection are used: (1) *warm-stool technic*; (2) *routine or cool-stool technic*.

The warm-stool technic is used for diarrheal or semi-liquid stools, purgation stools, and for material aspirated from ulcers or abscesses. Since such material may contain vegetative

4. Towse, R. C., Berberian, D. A. and Dennis, E. W.: Amebiasis in the Albany Area. N. Y. State Jour. Med., 50:17 (1950).

5. Jeska, E. L. and Gentzkow, C. L.: Is Pennsylvania Wormy? Penna. Med. Jour., 60:1579 (1957).

TABLE 2.

PATHOGENIC INTESTINAL PARASITES OF MAN

Class	Genus and Species Infecting Man	Habitat	Disease
	PROTOZOA		
1. *Amebas*	Endameba histolytica	Colon	Amebiasis
	Dientameba fragilis	Colon	Diarrhea
2. *Flagellates*	Giardia lamblia	Sm. Intestine	Giardiasis
3. *Ciliates*	Balantidium coli	Colon	Balantidiasis
4. *Sporozoas*	Isospora hominis	Colon and Ileum	Diarrhea
	Isospora belli	Colon and Ileum	Diarrhea
	METAZOA		
	Roundworms		
1. *Nematodes*	Enterobius vermicularis (Pinworm)	Colon	Enterobiasis
	Trichuris trichiura (Whipworm)	Colon	Trichuriasis
	Ascaris lumbricoides (Common roundworm)	Sm. Intestine	Ascariasis
	Necator americanus	Sm. Intestine	Hookworm infection
	Ancylostoma duodenale (Hookworms)	Sm. Intestine	
	Strongyloides stercoralis	Sm. Intestine	Strongyloidiasis
	Trichinella spiralis (Trichina worm)	Sm. Intestine and Muscles	Trichinosis
	Tapeworms		
1. *Cestodes*	Hymenolepis nana (Dwarf tapeworm)	Sm. Intestine	Hymenolepiasis
	Taenia saginata (Beef tapeworm)	Sm. Intestine	Taeniasis saginata
	Taenia solium (Pork tapeworm)	Sm. Intestine	Taeniasis solium
	Diphyllobothrium latum (Fish tapeworm)	Sm. Intestine	Diphyllobothriasis
	Flukes		
1. *Trematodes*	Fasciolopsis buski (Large intestinal fluke)	Sm. Intestine	Fasciolopsiasis
	Schistosoma mansoni (Manson's fluke)	Colon	Schistosomiasis
	Schistosoma japonicum (Oriental blood fluke)	Colon	Schistosomiasis

forms of protozoa which are easily destroyed by cooling, the specimens must be kept warm from the time of collection to, and during, the time of examination. No more than one hour should elapse between time of collection and examination.

The routine or cool-stool technic is used for collection of normally passed, formed stools which may contain the cystic forms of protozoa, as well as metazoal forms. These withstand cooling and drying for many hours so that submission to the laboratory may be delayed as long as 24 hours.

For preservation of fecal material for delayed laboratory examination, the use of Merthiolate®-iodine-formaldehyde (MIF) fixative stain and polyvinyl alcohol fixative (PVA) are valuable.*

These *precautions* are imperative in the collection of fecal material: (1) Containers must be clean and dry, and for diarrheal stools, warm; (2) Stools must not be mixed with germicides or urine; (3) Stools must be free of oil (mineral, cod-liver, castor), bismuth, iron, and barium, all of which make specimens unsuitable for examination. The common practice of ordering a barium enema first,

*For a complete description of these formulas and their uses, the reader is referred to Belding: *Basic Clinical Parasitology*, Appleton-Century-Crofts, 1958, or any other standard parasitology text.

and stool examinations *after* the x-ray is to be condemned.

Sequence of examinations: (1) In the presence of diarrhea, at least one stool should be examined daily for several days; (2) In the absence of diarrhea, at least 3 normally passed stools should be examined (one daily, or preferably, one on each of three alternate days). If these are negative, a stool following a purge should be examined; (3) during the period of stool examinations, proctosigmoidoscopy should be performed with removal of suspicious material by aspiration or biopsy.

In the event that these examinations are negative but parasitic infection is still suspected, the sequence should be repeated after the lapse of 5 to 7 days. A single negative stool examination should never be considered conclusive evidence of the absence of parasitic infection!

Occasionally, the only evidence of parasitic infection will be a lesion involving an organ other than the bowel. Thus, an amebic liver abscess or schistosomal cirrhosis may be diagnosed by finding, respectively, trophozoites or ova. Similarly, pus aspirated or expectorated from an amebic lung abscess may reveal organisms not demonstrable in stool examinations.

Laboratory examinations: The microscopic detection of parasites will be enhanced by the use of the (a) direct wet smears, unstained or iodine-stained, (b) iron-hematoxylin stained direct smears, and (c) smears made after concentration of material by the zinc sulfate or other concentration technic. Sawitz[6] showed that numerous stool examinations, the performance of all three types of smears, and attention to details relative to collection, preservation, and sequence of examinations will achieve an accuracy of 90 to 95 per cent in the diagnosis of protozoal, and practically 100 per cent in the diagnosis of metazoal infections.

TREATMENT

THE treatment of parasitic diarrheas entails the use of general, specific chemotherapeutic, and surgical measures. As in other diarrheas, bed rest, sedatives (emotional and intestinal), maintenance of chemical and fluid balance, and a low residue, high protein diet supplemented by vitamins are important. Surgical complications may occur; anorectal fistulas or abscesses, intestinal obstruction by a knotted mass of ascarids, liver or lung abscess, bowel strictures or malignancy, may require surgical intervention.

Specific chemotherapy: There are now many parasiticidal drugs which are effective and relatively safe. Successful treatment requires drugs which are destructive to or allow expulsion of parasites with no or minimal toxic effects on the patient. Although it is permissible to use a drug empirically on occasion, a positive diagnosis should be attempted in every case. Intelligent treatment calls not only for administration of a specific drug in proper dosage, but also for a knowledge of length of administration, possible side effects and cumulative properties, as well as a realization that a combination of parasites may require the use of a drug different from one which is indicated in the presence of a single species. First, let us consider *protozoal infections*.

PROTOZOAL INFECTIONS

1. *Amebic diarrhea*: In severe diarrhea or dysentery, the drug of choice is *emetine hydrochloride*. This is a dangerous drug so its use should be reserved only for the very severe case, or where other treatment has been ineffective. It acts only on the trophozoites in tissues and will usually produce remission of symptoms in a few days. It is curative in less than one-third of cases. The *dose* of emetine is 1 milligram per kilogram of body weight per day subcutaneously (average dose for adult is 65 milligrams or 1 grain per day), treatment not to exceed 5 to 7 days, and not to be repeated until after the lapse of at least a week. Electrocardiographic evaluation of the heart should be carried out before and during treatment. Children under 8 years of age should not receive emetine.

Oxytetracycline may be given concurrently

6. Sawitz, W. G.: Medical Parasitology. The Blakiston Company, 1950. Philadelphia.

with emetine, or instead of it, for 10 days, in a dose of 500 milligrams q.i.d. orally. Following this antibiotic, a course of Diodoquin® is given, followed by a course of Carbarsone® or Milibis®. The *dose* of Diodoquin® is 0.065 Gram, orally, t.i.d. for adults, continued for 20 days; children 40 to 75 pounds receive the dose twice daily, and those under 40 pounds receive 0.32 Gram, t.i.d. Carbarsone® is given in a dose of 0.25 Gram, orally, t.i.d., for 10 days. Milibis® is given orally in a dose of 0.5 Gram, t.i.d., for 10 to 14 days.

Courses of drugs may be repeated or alternated. Stools should be examined several times during the six-month interval after treatment stops.

Chloroquine phosphate (Aralen®) is important in preventing and treating acute hepatitis and liver abscess. It is given in an initial dose of one Gram daily, orally, for 2 days, followed by 0.5 Gram daily for 2 to 3 weeks.

2. *Giardiasis*: Quinacrine (Atabrine®) is effective. It is given orally for 5 days. The dose for adults is 100 milligrams, t.i.d.; for children 40 to 75 pounds, 100 milligrams, b.i.d., and under 40 pounds, 50 milligrams, b.i.d.

3. *Balantidiasis*: Oxytetracycline (Terramycin®) in the same dosage as for amebiasis, and Diodoquin®, in a divided daily dosage of two Grams per day appears to be curative.

4. *Dientameba fragilis diarrhea*: Treatment with standard antiamebic drugs (Diodoquin®, Carbarsone®, Terramycin®) appears to be curative.

5. *Isospora hominis and belli*: Infection is self-limited. Treatment is symptomatic. There is no specific drug.

ROUNDWORM INFECTIONS

1. *Enterobiasis*: (a) Piperazine citrate (dosage expressed in terms of piperazine hexahydrate) is given orally as orange-flavored syrup containing 100 milligrams per cubic centimeter or in tablets containing 500 milligrams; wafers to be chewed are also available. The drug should be taken before breakfast and followed by a glassful of water, which carries the drug more quickly to the cecum and colon. Treatment is continued for 7 consecutive days. The following dosage schedule is recommended:

Weight of Patient	Piperazine Syrup	Piperazine Hexahydrate
Up to 15 lb.	2.5 cc.	0.25 Gm.
16 to 30 lb.	5.0 cc.	0.50 Gm.
31 to 60 lb.	10.0 cc.	1.0 Gm.
Over 60 lb.	20.0 cc.	2.0 Gm.

(b) Dithiazanine is the newest drug, marketed under the name of Delvex® (Lilly) and Abminthic® (Pfizer). It is given orally in tablet form. For dosage see Table 3.

2. *Ascariasis*: (a) Piperazine as for enterobiasis, except in dosage of 75 milligrams per kilogram daily, in 2 divided doses, given for two days. (b) Dithiazanine: see Table 3.

3. *Trichuriasis*: Dithiazanine. See Table 3.

4. *Strongyloidiasis*: Dithiazanine. See Table 3.

TABLE 3.
DITHIAZANINE
(Delvex®—Lilly; Abminthic®—Pfizer)

Total Daily Dosage Schedule. To Be Divided Into 3 Doses.
(In children daily dosage may be divided into 2 doses if 3 are impractical)

Infection	Children			Adults & Children	Days	Cure (%)
Weight in lbs.	20-30 mg.	30-40 mg.	40-50 mg.	50-60 mg.	over 60 mg.		
Enterobiasis	100	150	200	250	300-600	5	100
Ascariasis	200	300	400	500	600	5	67
Trichuriasis	200	300	400	500	600	5	99
Strongyloidiasis	200	300	400	500	600	10-14	89
Multiple	200	300	400	500	600	5	?

Modified from Brown, H. H.: Treatment of intestinal parasitic infections encountered in N. America. Seminar Report, Spring 1957.

5. *Hookworm infection*: (a) Tetrachlorethylene is the drug of choice. It is given in a dose of 3 to 5 cubic centimeters for adults, and 0.06 cubic centimeter per pound of weight for children; it is administered in soft gelatin capsules; or it may be mixed in a small amount of water or with sugar. It is not necessary to purge the patient, but pre-treatment preparation should consist of a light evening meal the night before and omission of breakfast on the morning of treatment. Food may be taken 4 to 5 hours after the medication. Alcohol and fats are avoided for at least 24 hours preceding treatment.

If Ascaris is also present, tetrachlorethylene (2.5 cubic centimeters) is combined with oil of chenopodium (0.5 cubic centimeter); adults take the entire dose, children take 0.2 cubic centimeter per year of age up to the adult dose. Dithiazanine may be used to treat the ascaris infection first, to be followed by tetrachlorethylene. Failure to remove ascarids before administration of tetrachlorethylene may result in abnormal migration of these worms, and serious complications.

6. *Trichinosis*: The diarrheal phase of trichinosis is usually short-lived and this infection is usually not suspected until extraintestinal manifestations occur. There is no specific treatment.

C. *Tapeworm infection*: The treatment of choice for all tapeworm infections is Quinacrine (Atabrine®). The adult total dose is 0.8 Gram, best given in 4 divided doses of 0.2 Gram each, at half-hourly intervals. To lessen the possibility of vomiting due to gastric irritation, it is best to give a 10 grain tablet of sodium bicarbonate with each dose of quinacrine. For children 40 to 75 pounds, the dose is 0.4 Gram, and for 76 to 100 pounds, 0.6 Gram.

These preparations are important: On the day prior to treatment, the patient is placed on a liquid diet, with no evening meal except black coffe, tea and water. The following morning, breakfast is omitted and the treatment started. Two hours after the last dose of quinacrine a saline purge is given. All stools passed from the time of start of the medication till about four hours after the first effect of the purge should be collected in a clean receptacle and the material examined by a competent person to make sure whether or not the scolex has been passed.

FLUKE INFECTIONS

1. *Fasciolopsiasis*: Hexylresorcinol is the drug of choice, given orally or transduodenally. The oral dose is 1.0 Gram for adults, 0.6 Gram for children 1 to 5 years, and 0.8 Gram for children 6 to 10 years. It is given on an empty stomach, food is withheld for 5 hours, and a sodium sulfate purge is given 2 hours after the drug. Transduodenally, the dose is one Gram in 20 cubic centimeters of water.

2. *Schistosomiasis*: Specific treatment is effective only in the early stages. Potassium antimony tartrate (tartar emetic), sodium antimony tartrate, stibophen (Fuadin®), and Miracil® (the last one being the only effective oral drug) are effective. However, these are highly toxic drugs and should not be administered by anyone without experience in their use.

SUMMARY

PARASITIC infections of the human intestinal tract constitute an important problem for the physician called upon to treat diarrheas. Parasitic diseases are more prevalent than is generally believed and a universal "parasite consciousness" is necessary in order that mistaken diagnoses be avoided. Stool examinations are indicated in every patient with diarrhea who has been in an endemic area, or who has diarrhea of more than fleeting duration. Stools should be examined by experienced personnel, and the proper methods of collection and preservation should be known by the physician. A single negative stool examination should never be taken as conclusive evidence of the absence of parasitic infection. Once a diagnosis of parasitic infection is established, general supportive plus specific therapy will usually result in cure.

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Boonton

Premedication for the Control of Postoperative Vomiting

As often happens, a useful drug is found to be of service in many areas not originally contemplated. Here is a report which suggests that, in addition to its other values, perphenazine is useful in preventing postoperative vomiting.

Postoperative vomiting usually is caused by anesthetic or analgesic barbituric acid derivatives [1] but occasionally by complications of surgery.[2] The dehydration and consequent fluid and electrolyte imbalance which follows uncontrolled vomiting [3] is especially dangerous during the immediate postsurgical period.

Several phenothiazine compounds, best known for their tranquilizing properties, have proved effective antiemetics. Four of the most commonly used phenothiazines were tested for their ability to protect against apomorphine-induced emesis in dogs; perphenazine (Trilafon®) was more effective than any of the others.[4] In additional laboratory studies perphenazine was shown to be 16 times more potent than chlorpromazine in protecting dogs against exogenous emetic agents.[5]

Wang's studies [5] indicate that perphenazine and some other phenothiazines challenge circulating emetic agents at the chemoreceptive trigger zone in the medulla. Morphine, meperidine, and similar anesthetic agents incite the emetic response at this zone.[3] The superior anti-emetic potency and versatility of perphenazine appear to be due to its greater affinity to the chemoreceptors.[5]

The therapeutic implications of these laboratory reports have been substantiated by clinical experience. Perphenazine, pre- or postoperatively, has been used successfully to prevent vomiting following surgery. Gready and colleagues [6] used meperidine and scopolamine anesthesia in 1000 obstetric patients of whom 700 also received 5 or 10 milligrams of perphenazine. The 300 patients who served as controls evidenced the usual high incidence of opiate-induced nausea and vomiting although there was little or no emesis among the perphenazine-treated group. Moore and colleagues [7] conducted a double-blind study among

1. Dobkin, A. B.: Canad. Anaesth. Soc. Journal, 5:177 (April) 1958.

2. Scurr, C. F. and Robbie, D. S.: British Medical Journal, 1:922 (April 19) 1958.

3. Cummins, A. J.: American Journal of Digest. Dis., 3:710 (October) 1958.

4. Rosenkilde, H. and Govier, W. M.: Journal of Pharmacol. & Exper. Therap., 120:375 (July) 1957.

5. Wang, S. C.: Journal of Pharmacol. & Exper. Therap., 123:306 (August) 1958.

6. Gready, T. G., Estrada, W. J. and Haden, J.: American Journal of Obstetrics and Gynec., in press.

7. Moore, Daniel C., *et al.*: Anesthesiology, 19:72 (February) 1958.

610 unselected surgical patients anesthetized with morphine, meperidine, scopolamine, or other barbiturates; half received small pre- and postoperative doses of perphenazine intramuscularly. The results showed a high degree of statistical significance: 18 per cent of the patients who did *not* receive perphenazine (but only six per cent of the treated patients) vomited after surgery.

A highly controlled double-blind study among surgical patients was reported by Phillips and colleagues.[8] These investigators administered 5 milligrams of perphenazine intramuscularly before and after surgery to 99 patients; 102 patients served as controls. Morphine and atropine were the anesthetic agents. Vomiting after surgery occurred in 39 per cent of the untreated group but in only 19 per cent of the patients who had received perphenazine. Scurr and Robbie[2] conducted a similar study: half of 200 consecutive surgical patients received 5 milligrams of perphenazine intramuscularly immediately after surgery. All other influencing factors in the two groups of patients were equal or randomized. Vomiting occurred within six hours of surgery in 21 of the 100 patients who had not received perphenazine and in seven of the 100 patients who had.

Perphenazine apparently possesses numerous advantages which make it especially suitable for administration to surgical patients. Its marked anti-emetic potency at low dosage, coupled with relative freedom from toxicity, provide an exceptionally high therapeutic index.[9] Most authors commented on the fact that perphenazine, unlike most other phenothiazines, provokes little or no hypotension among normotensive patients. The drug apparently does not depress respiration,[1] deepen narcosis,[7] or impair liver function.[1] There is no pain on intramuscular injection.[2]

A higher incidence of drowsiness was observed by one team[8] among the patients treated with perphenazine. This was not a disadvantage among postoperative patients. Recovery time may be slightly prolonged.[2] Perphenazine has some ability to potentiate narcotics[10] but only in doses in excess of 10 milligrams.[6]

A further advantage of perphenazine as premedication for surgery derives from its tranquilizing properties: it helps alleviate the anxiety most patients feel at the prospect of an operation. It probably acts in the subcortical reticular activating system to block the transmission to the cortex of excitatory impulses.[1]

MATERIALS AND METHODS

THE combination of agents used in this study was chosen to approximate, as closely as possible, the ideal of anesthetic management as summarized by Dobkin:[1] a mild hypnotic on the eve of surgery for restful sleep; pre-operative medication to relieve anxiety during preparation for surgery and to protect against vomiting; drugs for the appropriate level of surgical anesthesia; and provision for continued anti-emetic, ataractic, and analgesic control after recovery from anesthesia.

This series consisted of 102 consecutive unselected patients representing a normal surgical population. Perphenazine,* 5 milligrams intramuscularly for adults and 2.5 or 1.25 milligrams for children, was administered preoperatively to all patients in an attempt to reduce the incidence of postoperative emesis. The drug usually was given more than an hour before the start of anesthesia so that its marked tranquilizing effect would operate during the immediate presurgical period.

Most patients received some type of sedation on the night before operation. The duration of anesthesia was calculated as the interval between induction and returning consciousness. The types and amounts of anesthetic agents were adjusted for body weight. In the four patients who received only local or spinal analgesia, and to whom no centrally-acting drug other than perphenazine was ad-

8. Phillips, Otto C., *et al.*: Anesthesia and Analgesia, 37:341 (December) 1958.

9. Irwin, S. and Govier, W. M.: Journal of Pharmacology and Exper. Therapy., 119:154 (February) 1957.

10. Mathewson, H. S.: Journal-Lancet, 77:387 (October) 1957.

*The perphenazine (Trilafon®) for this study was provided by George Babcock, Jr., M.D., Division of Clinical Research, Schering Corporation, Bloomfield, New Jersey.

ministered, the only indication for this drug was pre-operative tranquilization. Postoperative sedation was administered when indicated.

RESULTS

THE incidence of postoperative emesis was much lower than would be expected in a normal surgical population. Of 102 patients, 92 did not vomit, nine had a slight amount of vomitus, and one had a fair amount.

We attempted to correlate the instances of vomiting with other anesthetic variables such as time of drug administration, duration of anesthesia, and amounts and types of other agents used but in general these factors did not differ between those patients who vomited and those who did not. However, there was one patient who vomited slightly after surgery and who had been given perphenazine 90 minutes before being taken to the operating room and anesthetized for almost six hours. Since the duration of action of perphenazine is approximately six hours, we believe that the effect of the drug wore off before the patient regained consciousness. It may have been possible to prevent postoperative emesis by administration of another dose of perphenazine in the operating room.

Three of the ten patients who vomited were children who received only 1.25 milligrams of perphenazine. A slightly higher initial dose or a second dose at the same level after surgery have been effective. Perphenazine probably reduced the severity of emesis in an adult patient who vomited considerably before administration but only slightly after surgery.

The tranquilizing effect of perphenazine was also evident in this series, especially among the six children. They were notably quiet and cooperative during preparation for surgery. Two of our adult patients had shown marked apprehension while being prepared for previous surgeries; during the current experience, after administration of perphenazine, they were quiet and cooperative. A third patient, who was especially apprehensive at admission, was calmed considerably after administration of perphenazine although there was a return of anxiety upon awakening from anesthesia. Two patients with previous histories of excitement during recovery awakened quiet and calm after premedication with perphenazine.

There were no apparent adverse reactions to the perphenazine except in one child (who did not vomit) who evidenced mild tremors during reaction. Parkinsonian tremor is an occasional transient side effect of perphenazine but usually this occurs only after dosage much higher than that used in this study. The child may have had an exceptionally low threshold of response to this drug.

OF THE 102 patients, the blood pressure was recorded both before and after surgery in 72; of these latter, 42 patients (58 per cent) showed a decrease in either systolic or diastolic blood pressure of 10 or more millimeters or greater. Nineteen (26 per cent) showed an elevation in either systolic or diastolic blood pressure of 10 millimeters or more. These variations are not significantly different from those seen in a random surgical population. Perphenazine cannot be considered responsible for lowered blood pressure values after surgery because the blood pressure tends to rise slightly immediately before surgery. The postoperative values are more nearly those of the patients on admission.

A 46-year old woman was admitted for tendon surgery of a finger. Her height was 59 inches, her weight 140, and blood pressure 106/70. At 9:45 a.m. on the day of surgery she was given 25 milligrams of promethazine. At 11:10 a.m. secobarbital grains 1½ and atropine grain 1/50 were administered. The operation, which lasted 30 minutes, was begun at 12:50 p.m.; the anesthetics were 4 per cent thiopental sodium, propane, and oxygen. At 1:45 p.m. 50 milligrams of meperidine were administered and she was returned to her room from the recovery room reacting well and apparently in good condition. However, nausea and vomiting began shortly thereafter and lasted all day. At 8:15 p.m. 25 milligrams of chlorpromazine were given intramuscularly. This controlled the emesis. She was asleep at 11 p.m. On the following day her appetite and general condition were good. Vomiting did not recur, and she was ambulatory.

She was readmitted to the hospital on October 23, 1958, with acute appendicitis. She expressed dread at the prospect of general anesthesia be-

cause of the previous postoperative vomiting. She was given 5 milligrams of perphenazine at 6 a.m. on the day of surgery, and scopolamine grain 1/150 at 7 a.m. The appendix and an ovarian cyst were removed at 7:50 a.m. The operation required 2 hours. At 10:20 a.m. she was given 100 milligrams of meperidine. At 11:20 a.m. she reacted satisfactorily and was given 5 milligrams of perphenazine. At 3:45 p.m. she received 100 milligrams of meperidine. At 6 p.m., we gave 5 milligrams of perphenazine, and at 2 a.m. meperidine again. Pulse and blood pressure were within normal limits throughout the day. On the morning after surgery she began to receive 4 milligrams perphenazine orally 3 times daily.

The patient did not at any time experience nausea or vomiting. Recovery was uneventful and comfortable.

SUMMARY

PERPHENAZINE was administered as pre-operative medication to 102 unselected patients who were anesthetized with atropine or scopolamine. Perphenazine markedly reduced the incidence and severity of vomiting which would have been expected after anesthesia. Ten patients vomited, nine only slightly. Perphenazine was also useful in relieving apprehension during preparation for surgery and recovery from anesthesia. There appeared to be no significant adverse reactions to this drug.

135 Cornelia Street

Mouth to Mouth Said to be Best Life Saver

The American Red Cross, acting on the unanimous judgment of the National Academy of Sciences, has adopted mouth-to-mouth technic as the best life-saving method for adults and children. If you do not keep your JOURNALS, cut out the instructions below and keep them handy. Here is the technic:

1. Quickly wipe out any foreign matter in the mouth. Use a handkerchief-wrapped finger.

2. Tilt the head back so the chin is pointing upward. Pull or push the jaw into a jutting-out position. These maneuvers should relieve obstruction of the airway by moving the base of the tongue away from the back of the throat.

3. Open your mouth wide and place it tightly over the victim's mouth. At the same time pinch the victim's nostrils shut or close the nostrils with your cheek, or close the victim's mouth and place your mouth over the nose. Blow into the victim's mouth or nose. Air may be blown through the victim's teeth, even though they may be clenched. The first blowing efforts should determine whether or not obstruction exists.

4. Remove your mouth, turn your head to the side, and listen for the return rush of air that indicates air exchange. Repeat the blowing effort.

5. There are two major differences in procedure between administering mouth-to-mouth resuscitation to a child and to an adult. One applies to the breathing itself. For a child, take relatively shallow breaths appropriate to the child's size at the rate of about 20 a minute. For an adult, blow vigorously at the rate of about 12 breaths a minute.

The other difference relates to initial failure to get air exchange. If this occurs, recheck head and jaw position. In the case of a child, upend it by holding the ankles and administer two or three sharp slaps between the shoulder blades. An adult, who cannot be lifted easily, can be turned on his side so that the blows on the back can be given in an effort to dislodge obstructing matter.

6. Rescuers who do not wish to come in contact with the victim may hold a cloth over the latter's mouth or nose, and breathe through that. The cloth does not greatly affect the change of air.

7. The Red Cross still considers manual methods of artificial respiration acceptable for rescuers who cannot or will not use the mouth-to-mouth or mouth-to-nose technic. The two methods it recommends are the Nielsen back pressure-arm lift method and the Silvester chest pressure-arm lift method.

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Skin Disease Involving Animal Contacts

The veterinarian should be called as a consultant in cases of tinea capitis (or other skin disease) involving animal contacts. Immediate destruction of a pet cat or dog is cruel, sometimes useless, and often unnecessary.

Professional relationships between physicians and veterinarians with isolated exceptions are not adequately functional. Contacts are usually indirect as through patients who are pet owners. This often leads to misunderstandings, tactless statements and estrangement of the two professional groups. Physicians, veterinarians and the public are contributory in the responsibility of this poor relationship. To correct this situation, a joint committee was appointed with members of each society, by the N. J. Dermatological Society and by the Veterinary Medical Association of N. J.

One of the outstanding problems involving both professions is that of ringworm of the scalp. Three types of tinea capitis[1] are common to this area: (a) due to Microsporum canis; (b) due to Microsporum audouini; and (c) due to Trichophyton tonsurans. The second and third forms are passed from one human being to another.

The type of tinea caused by Microsporum canis, however, is readily transmitted from infected animals usually the dog and the cat to humans, and also to some extent from human to human. An extensive example was recently reported.[2] Owners of such animals are often told to have the suspected pet destroyed. This unwarranted decision is usually unnecessary and frequently erroneous. To the veterinarian assigned such a task there is a natural resentment at being relegated to the role of executioner without the benefit of his own professional judgment. It is of interest that the human type of ringworm has been transmitted to animals.[3]

Intestinal parasites are, in general, specific for their host such as the dog, cat, or human. Parasites such as the pinworm, oxyuriasis which exists in humans are often erroneously attributed to contact with a household pet. Such misinformation is often unwittingly given to parents by physicians. The fact explained here needs only to be mentioned to prevent further propagation of such errors. On the other hand tuberculosis in smaller animals is usually of human origin and here *the animal needs protection from his human contacts.*

Fleas are a problem in two ways. They bite

1. Lieberman, J., *et al.*: Animal Disease and Human Health. Annals of the New York Academy of Sciences, 70:636 (1958).

2. Ferguson, E. H.: Epidemic Due to Microsporum canis. A.M.A. Arch. Dermat., 78:506 (October) 1958.

3. Kaplan, W. and Georg, L. K.: Isolation of Microsporum audouini from a Dog. J. Invest. Dermatology, 28:313 (1957).

human contacts. Insecticides used to destroy them can cause allergic and toxic reactions to humans. Authoritative advice is necessary in the treatment of persistent cases. Other examples also occur.

We recommend the following steps in suspected cases of ringworm:

1. Laboratory confirmation by the physician of the disease as a fungus disease, tinea capitis; identification of the organism as Microsporum canis which could have been acquired from an animal. In most cases, an excellent aid in the confirmation of the diagnosis of tinea capitis is accomplished with a Wood's light. This reveals a fluorescent green color in the infected hairs. Identification of the specific organism can best be done in a laboratory with mycologic facilities. The State Health Department laboratory, or a private laboratory may be used for this purpose.

2. The suspected animal should be brought to a veterinarian for an examination and where necessary appropriate laboratory tests used for diagnosis and fungus identification. Many instances occur where the animal placed under suspicion is not diseased.

3. If it is established that a particular animal is the cause of the tinea capitis, this should be reported to the local health officer. It should be a "reportable disease."

Dogs are responsive to therapy. Relative isolation of the animal can be effected in a garage, basement, empty room, animal hospital or in any other confinement area that can be sanitized. This avoids latent infection from furniture, rugs and other household furnishings.

Cats are more difficult to treat. Close cooperation of the veterinarian and the family is necessary.

4. Prophylactic measures include avoidance and isolation of infected animals. Infected children need protective head coverings plus active medical therapy. The treatment of the patient and the animal is described in detail in standard texts.[4]

4. Conant, A., *et al.*: Manual of Clinical Mycology, Saunders. Philadelphia (1958).

7 Watchung Avenue

Loan Fund for Interns and Residents

A $400,000 George W. Merck Memorial Loan Fund has been established by The Merck Company Foundation to assist deserving interns and residents to seek graduate training in teaching hospitals before entering practice. Participating are the medical schools associated with the following universities: Boston, California, Chicago, Columbia, Cornell, Harvard, Illinois, Johns Hopkins, New York, Northwestern, Pennsylvania, St. Louis, Tufts, Vanderbilt, Vermont, Virginia, Washington (St. Louis), and Yale.

Graduates of other medical schools may be eligible for loans if they take the internship or residency at any of the 48 teaching hospitals affiliated with the participating schools.

Administration of the Fund will be by the deans of the medical schools, who will select the recipients, the amount of each loan, and the terms of its repayment. The Merck Company Foundation will allocate the $400,000 over a period of eight years, by which time the Fund is expected to become self-sustaining. First funds are already available.

The Memorial Fund was established in honor of the late George W. Merck, former president of Merck & Co., Inc. During his lifetime Mr. Merck had a dedicated interest in the progress of medical knowledge.

The Merck Company Foundation is a nonprofit corporation supported by Merck & Co., Inc. It makes contributions to education and other worthy causes.

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New Brunswick

Cardiovascular Disease Among Physicians*

Here is a paper which, our readers will agree, is on the most interesting subject in the world: us. Coronary artery disease, we are glad to learn, is really not a monopoly of physicians. Business executives have more of it than we do.

This report is the outgrowth of interest in physician mortality in New Jersey by the Division of Chronic Illness Control of the New Jersey State Department of Health and the Special Committee for the Chronically Ill and Aging of The Medical Society of New Jersey. It has long been felt that cardiovascular diseases are the diseases of doctors. Physicians are particularly prone to develop cardiovascular disorders. In a recent survey by the American Medical Association[1] covering a period when 3169 physicians' deaths were reported, 2239—or 71 per cent—were due to cardiovascular diseases. This is significantly higher than the average of 53 per cent cardiovascular deaths among the general population. The highest death rate[2] in this group occurred in the age bracket 60 to 64. Except for cardiovascular diseases (and possibly diabetes) the mortality rate for all other causes is significantly *lower for physicians than in the general population*. It is of interest that age-expectancy of physicians has increased. Since 1925, the life expectancy of physicians at age 30 rose from 68 to 71 years and at age 50 from 71.7 to 73.2 years.[2] Life expectancy appears to be greater among the specialists' groups than the non-specialists except in coronary disease.

To compare the New Jersey experience with the country as a whole, the mortality statistics for 1957 were reviewed.

PHYSICIAN MORTALITY

New Jersey 1957

Total number of deaths	99 or 100 per cent
Cardiac deaths	65 or 66 per cent

Of these 65:

1 was from rheumatic heart disease
15 from hypertensive disease
49 from arteriosclerotic disease

There were 99 physician deaths in New Jersey in 1957; of these 65 were due to cardiovascular disease. These represent 66 per cent of the total and compare almost exactly to the national figures. One can conclude that there is a statistical increase in mortality due to cardiovascular disease among physicians as compared to the general population and that the New Jersey experience compares almost exactly to the national statistics.

Although these mortality figures are of interest, it was thought that an analysis of the incidence of cardiovascular disease among living physicians might reveal some significant information. Accordingly, the Division of Chronic Illness Control of the State Depart-

*Read April 29, 1959 before the Cardiovascular Section ot The Medical Society of New Jersey.

1. Dickinson, F. and Martin, L.: Journal of the American Medical Association, 162:1462 (May) 1956.

2. Dublin, L. and Spiegelman, M.: Journal of the American Medical Association, 134:1211 (November) 1947.

ment of Health drew up a questionnaire which was sent to 427 New Jersey physicians. These represent the same sampling used by a Columbia University School of Public Health group when studying a similar statistical problem among physicians in New Jersey two years ago. Actually, this group represents every eleventh physician in the state. The 260 replies received constitute the source of our case material. In this group there were 247 males and 13 females. Below is the questionnaire.

DO NOT SIGN YOUR NAME

1. Age . . Sex . . . . .
2. Do you have (have you had) Heart Disease? . . . .
   If yes, check which kind
   Rheumatic . . . . . Arteriosclerotic . .
   Hypertensive . . . . Other . . . .
3. Do you have (have you had) Hypertension? . . .
4. Are you overweight . . . . .
   If yes, slightly . . . moderately . . . excessively . .
5. How would you describe the stress and strain under which you work and live?
   None . . . slight . . . . moderate . . excessive . . .
6. Have you had a physical check-up in the past 1 yr. . . . . 2 yrs. . . . . 3 yrs. . . . . .
   Did this include: Electrocardiogram . . . . . Chest x-ray . . . . . .
7. With respect to arteriosclerosis, is your diet restricted in fats or cholesterol?
8. Do you have (have you had) Diabetes Mellitus? . . . . .

The factors we were interested in were hypertension, obesity, stress and strain, diet, and diabetes. Further, we thought that a question on physical examination would be of some interest.

The results were as follows:

	No.	Per Cent
Negative	235	90
Positive	25	10
Rheumatic heart disease	3	12
Hypertensive heart disease	7	28
Arteriosclerotic heart disease	13	52
Other	2	8

1. Coarctation of Aorta
2. Thyrotoxic

There were 235 negatives and 25 or 10 per cent positives. Of the 25 cases of known heart disease 12 were due to rheumatic heart disease 28 per cent to hypertensive heart disease, and 52 per cent were due to arteriosclerotic heart disease. Further, there was one case of coarctation of the aorta and one of probable thyrotoxic heart disease with frequent bouts of paroxysmal tachycardia.

ASSOCIATED PARAMETERS IN NON-CARDIAC GROUP (235 Cases)

	No.	Per Cent
Hypertension	19	8
Obesity	125	48
Stress and strain	250	96
Dietary restriction	88	34
Diabetes	3	1
Physical exam within 3 yrs.	207	80

Of the 235 non-cardiac physicians 8 per cent stated they had hypertension. Forty-eight per cent stated they were obese; 96 per cent said they lived under excessive stress and strain; 34 per cent stated they were on dietary restrictions. Two of the doctors had diabetes. Eighty per cent had undergone physicial examinations in the past three years. On comparing these various parameters between the cardiac and the non-cardiac groups we found the following results:

	Cardiac (25 Cases)		Non-Cardiac (235 Cases)	
	No.	%	No.	%
Hypertension	7	28	19	8
Obesity	10	40	125	48
Stress and strain	23	92	232	97
Dietary restriction	13	52	88	34
Diabetes	2	8	3	1

In the cardiac group there were 28 per cent with hypertension and in the non-cardiac group only 8 per cent. Of those in the cardiac group 40 per cent were obese, and 48 per cent of the non-cardiac group stated they were obese. Of the cardiacs 92 per cent said that they were operating under stress and strain; in the non-cardiac group 97 per cent reported the same factor. More than half of the cardiac group were on dietary restrictions, for treatment, of course; and 34 per cent of the non-cardiac group stated they were on dietary restriction. This group was obviously for prevention. Eight per cent of the cardiac group had diabetes and only 1 per cent of the non-cardiac group admitted to diabetes.

It would appear, therefore, that *hypertension and diabetes are statistically significant factors in the incidence of cardiovascular disease* in this sampling of New Jersey physicians. Obesity is a well-known associated factor. The non-cardiac New Jersey physician is slightly more obese than his cardiac colleague.

This may represent a weight-reduction regime as part of the usual treatment in the cardiac group. This would appear to be borne out by the increased dietary restriction as to fat and cholesterol in the cardiac when compared to the non-cardiac group.

The frequency of physical examinations among the New Jersey physicians compares favorably to other reports where the ratio varied from 40 to 65 per cent. In a recent survey,[3] less than half of 9396 doctors polled had submitted to a physical examination in the past year and a half. In physical examinations of doctors during the past three annual meetings of the American Medical Association 18 per cent of nearly 3000 electrocardiograms were interpreted as abnormal or borderline. An equal proportion of chest films showed suspected or definite abnormalities, including tuberculosis, chest neoplasms, and cardiovascular abnormalities. Previous studies of physicians' health have indicated similar percentages. The amount of unsuspected pathology uncovered during these limited examinations should convince doctors that they should have periodic physical examinations.

There has been a great deal of comment and publicity concerning the relationship of stress and strain to cardiovascular disease. Russek,[4] in a study of 100 young coronary patients, found occupational stress to be more important than a positive family history of cardiovascular disorders, a high-fat diet, obesity, tobacco, or exercise. Friedman and Rosenman[5] recently reported a study which suggested that the intense competitive driving businessman may well be more prone to heart disease than the easygoing individual who does not care about success. In their study, three groups of men were selected. In the first were 83 with the behavior pattern characterized by intense ambition or drive. They were also of superior mental and physical alertness and continuously worked against deadlines. The second group consisted of 83 men, similar to the first in age, extent of physical activity, dietary habits, tobacco and alcohol consumption, but their behavior pattern was found to be the opposite: they showed little or no ambition or desire to compete. The third group of 46 unemployed blind men was included to study the role of anxiety and alertness apart from the factors of deadline pressure and ambition. After a year of follow-up and periodic examinations, the first group showed 6 to 8 times as much actual coronary heart disease as the other two groups. These hard drivers also had high blood levels of cholesterol and faster clotting times. Despite the anxiety of the blind men, their blood studies and heart status were similar to those of the easygoing group. Friedman and Rosenman[5] therefore concluded that these results point rather clearly to the probability that the factor of behavior pattern plays a very great role in the increased incidence of coronary artery disease in this country. Wolf[6] has further confirmed the relationship between stress and strain and the clinical and biochemical alterations occurring in arteriosclerosis. He views the coronary-prone person as one who is highly competitive in his attitude if not in his behavior, concerned with self-sufficiency and with doing things on his own, usually the hard way. Looking for new worlds to conquer, he takes less than usual satisfaction from achievement and especially has no time for resting points of satisfaction between chores. Physicians have been considered particularly vulnerable in this respect. However, when compared to other groups in the same economic and social level we find that we are not the most vulnerable group to stress and strain.

HOW PHYSICIANS COMPARE WITH OTHER MEN UNDER PRESSURE

Illness	% of Physicians' Illness	% of Findings in Health Exams. of Executives* Group A	Group B	Group C
Average age (years)	44.0	41.0	43.7	50.5
Hypertension	2.1	12.8	8.1	6.1
Heart disease	3.7	11.0	7.6	6.0
Peptic and duodenal ulcer	3.8	6.4	——	——
Diabetes	1.1	2.2	——	——
Rheumatic disease	1.8	10.8	——	——
Allergy	7.4	6.4	——	——
Gastrointestinal disorders	7.4	15.6	——	——

*Group A—500 males,[7] Group B—5,000 males,[8] Group C—1,171 males.[9]

3. Medical Science, 4:80 (July) 1958.
4. Russek, H.: *In press*
5. Friedman, M. and Rosenman, R.: *In press*
6. Wolf, Stewart.: *In press*

In a recent survey comparing physicians to other men under pressure, of the same age groups, we find that the incidence of heart disease is only 4 per cent among physicians and varying from 6 to 11 per cent in the various surveys in the business executive group.

These three groups constitute three different reports, one of 500 males,[7] the second of 5000 males,[8] and the third group of 1171[9] males. Average age is similar except in Group C, which is a slightly older group. This interesting fact had some basis in recent sociologic studies emphasizing the role of insecurity among the middle-aged business executives. Years ago a man working 25 years for a corporation had security in his position. Today, however, with mergers and impersonal corporate attitudes, many business executives lack job security despite high incomes. Physicians, on the contrary, who have just as much stress and strain, rarely lack security in their practices. Insecurity may be another factor in the higher incidence of heart disease among business executives compared with physicians in the same age group. Physicians as a group compare favorably with the business executives in the other disease categories as well. Arthritis, rheumatism, and gastrointestinal disorders are much more common in the business world than in the world of the physician.

In addition to hazards peculiar to the practice of medicine, the physician is subject to the hazards of the favored economic and social classes to which he belongs. He is also susceptible to the hazards due to the stress of work, frequently occurring among other professional persons such as executives, business leaders, foremen, and skilled workers; namely, vascular disease, peptic ulcer and alcoholism.[10]

The conclusion that coronary artery disease is the doctor's occupational disease must be accepted with caution. Master and Jaffe,[11] and Abrams [12] have contended that there is no preferential occupational distribution of coronary artery disease and that the apparent predilection for the medical profession suggested in the past may be due to statistical error.

SUMMARY

1. Mortality from heart disease among physicians in New Jersey is almost exactly the same as in the rest of the United States.

2. There is a statistically significant increase in physician mortality from heart disease—66 per cent—compared with the rest of the general population's 53 per cent.

3. In a survey among living New Jersey physicians hypertension and diabetes appear to be statistically significant factors associated with heart disease.

4. New Jersey physicians who are cardiacs are somewhat less obese and follow dietary restrictions more strictly than their non-cardiac colleagues.

5. Stress and strain occur in a vast proportion of all physicians throughout the nation; however, there is no statistical evidence to support the popular conception that coronary artery disease is the doctor's disease. Indeed, it would appear that coronary disease occurs more frequently among business executives of the same age group as physicians.

I would like to thank Dr. Leon Fraser, Coordinator of the Heart Disease Control Program of the State Department of Health, who was of invaluable aid in accumulating and helping to analyze these statistics.

155 Livingston Avenue

7. Thompson, C. E. and Staack, H. F.: Industrial Medicine, 25:151 (February) 1956.

8. Report by the New York Life Extension Institute Examiners on the Study of 5000 Executives. Bulletin of the Institute, March 1957.

9. Lee, R. E. and Schneider, R. F.: Journal of the American Medical Association, 167:1447 (October) 1958.

10. Dowling, H. F: *GP*, 11:69 (January) 1955.

11. Master, A. M. and Jaffe, H. L.: Journal of the American Medical Association, 148:794 (March) 1952.

12. Abrams, H. K.: *GP*, 9:36 (January) 1954.

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Endoscopic Resection of the Prostate*

Adaptation of Technic to Transvesical Prostatectomy

In prostatic surgery, urethral hygiene is an unglamorous and undramatic phase of the work. But as Dr. Glickman here points out it is of prime importance.

The usefulness of the resectoscope in urologic surgery is acknowledged by all. However, use of the resectoscope may be attended by unpleasant sequelae. Not every urethra will tolerate this instrument, as is so often manifested by the rapid development of a urethral stricture. Respect for the urethral meatus is perhaps the most important lesson to be derived from one's experience in transurethral surgery. Prior to insertion of a resectoscope, the meatus must be calibrated to determine its ready acceptance of the instrument. There must be no gripping of the instrument by the meatus, and certainly no splitting of the meatus by forcible introduction. Recognition of the fact that the former standard size, 28 French, was much too large in many instances, led to the manufacture of the interchangeable resectoscope, permitting the surgeon to employ a 24, 26, or 28 French sheath, with the same basic instrument block, merely by substituting the appropriate loop. The No. 26 sheath is of little use, for if the meatus is too narrow for the No. 28 sheath, it is preferable to use the No. 24, providing the meatus is adequate to tolerate this size, since it is wise to allow as much mobility within the urethra as can be achieved to avoid trauma.

Abuse of this principle will result in an immediate postoperative meatitis, which in turn will be likely to produce a meatal stricture, very resistant to dilatation, thereby altering unfavorably the functional outcome of the resection.

External urethral meatotomy has been employed widely to obviate the aforementioned problem, but this procedure in itself may produce a stricture subsequent to meatitis. If the meatus tends to be pinpoint in size, in the center of the glans, necessitating a wide incision into the thick glandular tissue, a poor result is more likely to occur than if the meatus is situated more eccentrically, located closer to the median ventral portion of the coronal sulcus, requiring incision into a thin groove in the glans. A suture type meatotomy in this instance, using interrupted sutures of 0000 chromic catgut, joining the urethral mucosa to the glandular skin is less likely to result in a stricture, than in the former instance.

Before the decision is made as to whether or not to perform a meatotomy, the surgeon should consider the type of suspensory ligament present. A short one can cause additional trauma to the bulbo-membranous urethra. In this situation, the resectoscope will traumatize the urethra against the under surface of the symphysis pubis when the surgeon attempts to resect the anterior portion

*Read by invitation on April 28, 1959 before the Section on Urology of and at the Annual Meeting of The Medical Society of New Jersey.

of the prostate. This too, can result in a urethral stricture. Therefore, in the combined presence of a small, poorly placed urethral meatus and a short suspensory ligament, it is preferable to incise the bulbous urethra and to introduce the resectoscope directly through the urethrotomy into the bladder. This technic completely by-passes the urethral meatus and pendulous urethra, sparing this area of trauma and preventing subsequent stricture. In addition, the unusual degree of mobility attained with the resectoscope in this position, greatly facilitates the transurethral prostatectomy. In our experience, it has been found necessary to perform external urethrotomy in 15 to 20 per cent of resections. At the termination of the resection, a catheter is passed through the external meatus into the bladder and the urethrotomy closed with interrupted sutures of 000 chromic catgut, leaving a small wick of gauze in the lower angle of the skin incison for 12 to 24 hours. In this instance the catheter is permitted to remain indwelling for five days to ensure adequate healing of the urethra. Occasionally the wound fails to heal *per primam* and the patient will leak urine through it during micturition. Should this occur, the catheter should be reinserted for an additional 3 to 5 days, which usually will be adequate for complete healing.

THE proper catheter is almost as important as the judicious use of the resectoscope to attain a postoperative urethra free of stricture. Just as too large a resectoscope will induce urethral trauma, urethritis and stricture, so will a large catheter that fails to permit adequate drainage of urethral secretions. Whereas formerly I almost routinely used a No. 22 French pear-shaped 75 cubic centimeter balloon Foley catheter for bladder drainage following transurethral prostatectomy, I now tend to use a No. 18 French catheter with 30 cubic centimeters balloon, wherever possible. In rare instances, where a very small meatus is present, and the operation was done *via* external urethrotomy, I have inserted a No. 16 French Foley catheter to avoid meatitis. If the surgeon has been able to secure good hemostasis at the termination of the procedure, there should be no necessity for a large calibered catheter. The diminished urethral reaction seen in response to a smaller catheter is gratifying as is the very much diminished incidence of postoperative stricture.

As a further precaution in the postoperative management, it has been found wise to anoint the urethral meatus throughout the day with a 0.5 per cent hydrocortisone ointment into which has been incorporated a versatile antibiotic. This regime is maintained until the catheter is removed, usually on the 3rd or 4th postoperative day, depending upon the degree of fever present as well as the gross appearance of the urinary drainage. During the period of catheter drainage it is important to cleanse the glans penis and adjacent portion of the catheter, freeing them of adherent dried blood and secretions.

Following removal of the catheter the patient is instructed to insert the tip of the cortisone ointment tube into the urethral meatus three times daily and to deposit there some of the medication. This is carried out for about a week postoperatively, or until there is no longer any manifestation of meatitis. Recently reported was the postoperative introduction into the urethra of suppositories containing nitrofurazone† and hydrocortisone which is believed will reduce the incidence of urethral stricture.[1] While I have not yet had any experience in this practice, it appears to have merit and should be given a trial.

Urethral hygiene has prime importance. A well executed prostatic resection will be defeated by insufficient attention to this area, whereas proper care at the time of operation and during the postoperative period will permit the patient to enjoy the fruits of his surgeon's labors.

Sufficient research on the subject of the nature of the irrigating medium to be used during the course of transurethral resection of the prostate has convinced all workers in the field that one must use a non-hemolytic solution. Any solution other than a non-hemolytic is a potential source of nephrotoxicity

†Available as Furacin® (Eaton).

1. Roll, W. and Waller, J.: Journal of Urology, 81:289 (Feb. 1959).

ending in a "lower nephron syndrome." A 1.1 per cent solution of glycine as proposed by Nesbit and myself [2] in 1948, has proved eminently satisfactory in the past 12 years.

A surgical unit employing a radio tube cutting current with spark gap fulguration will deliver maximum efficiency for transurethral surgery.

THE technic of encirclement of adenomatous tissue which diminishes blood supply to a median mass of tissue, so well evolved and discussed by Nesbit, should be followed for successful surgery. This operation has been divided into 3 phases: (1) excision of all intravesical extension of prostate with conization of the intra-urethral portion down to the prostatic apex, (2) removal of all urethral prostatic component to expose prostatic capsule, and (3) removal of apical tissue around the entire extent of the external sphincter.

Maximal removal of tissue in minimal time is facilitated in the first phase by maintaining the activated cutting loop in an extended position engaging tissue at its most proximal extent and withdrawing the entire sheath to the desired apical area before retracting the loop and shearing off the excised segment of tissue. This permits removal of strips of prostate which represent the combined length of intravesical protrusion and intra-urethral enlargement.

At the termination of the operation the bladder neck and prostatic cavity are adequately inspected for hemostasis as well as possible remnants of adenomatous tissue. The final inspection must include the bladder to ensure that no fragments of prostatic tissue remain, since they may constitute obstructing mechanisms, source of pyuria, or be the nidus for subsequent vesical calculus formation.

The presence or absence of significant venous bleeding from the prostatic capsule at the termination of the operation will determine whether the balloon of the indwelling catheter is to be inflated within the prostatic cavity or within the bladder lumen. Open venous sinuses may require compression by the inflated balloon for 12 to 24 hours to ensure hemostasis. As a rule, it is preferable to avoid traction on the catheter when the balloon is inflated within the prostatic cavity, since this may induce pressure necrosis of the external urethral sphincter with resultant incontinence. It is sufficient to strap the catheter to the thigh without traction, merely to prevent expulsion of the balloon into the bladder when the patient is shifted from the operating table onto a stretcher or onto his bed. After 12 to 24 hours the balloon is deflated to 10 cubic centimeters capacity and displaced into the bladder cavity, where it remains for an average of 3 days, prior to removal.

THE obvious advantages of transurethral surgery led to its adaptation to a technic for transvesical removal of the prostate. In 1948, in collaboration with Drs. A. Hyman and the late H. Evans Leiter, I presented a preliminary report [3] of a one stage suprapubic prostatectomy with transurethral fulguration and primary bladder closure. The operation is done with the patient in lithotomy position, the surgeon standing between the patient's legs at the foot of the table. An assistant stands above and behind each leg of the patient. After enucleating the prostatic adenoma, the surgeon introduces an appropriate sized resectoscope *per urethram*. Here the same principle as to judicious care of the urethral meatus and urethra holds true as in transurethral prostatectomy. We have learned to use this procedure only when the urethra will tolerate comfortably at least the No. 24 French resectoscope. The great advantage of this technic derives from the surgeon's ability to visualize well the bleeding arteries on the bladder neck and within the prostatic cavity and to coagulate them. No attempt is made to fulgurate venous bleeders. Although the surgeon has performed a good enucleation, he will be surprised often to visualize residual adenomata which can be resected readily. The occasional surprise discovery of a fixed

2. Glickman, S. I. and Nesbit, R. M.: Journal of Urology, 59:1212 (June 1948).

3. Glickman, S. I., Hyman, A. and Leiter, S. E.: Journal of the Mt. Sinai Hospital, 17:6 (April 1951).

prostate, involved by carcinoma, with no plane of cleavage, can be resected transurethrally with no further ado. The fulguration is carried out while the bladder is still open, leaving a suction tip in the bladder. The open bladder permits removal of all resected bits of tissue and blood clots, which might obstruct the catheter lumen. When hemostasis is secured, a 3-way balloon catheter is introduced *per urethram* and the balloon distended in the prostatic cavity to compress venous bleeding. The bladder incision is then closed in two layers. A strip of Penrose drain is placed in the infra pubic region and the abdominal wall closed around it in conventional fashion. The drain is shortened on the 3rd postoperative day and is removed on the 5th day.

THE chief source of concern to the surgeon who performs suprapubic prostatectomy is the control of primary hemorrhage. Our technic provides an excellent hemostasis and thereby permits primary closure of the bladder. This shortens the postoperative hospital stay, and makes the postoperative course more comfortable for the patient in that there is minimal tendency for bladder spasms and messy wet suprapubic dressings are eliminated.

The surgeon is spared the arduous task of resecting large sized prostatic adenomata, since by this method he can complete the operation in about one hour, and still offer the patient a closed urinary tract with a postoperative stay that is closely akin to that following transurethral prostatectomy. The indwelling catheter can be removed any time from the fifth to the seventh postoperative day, and has been removed as early as the third day with no ill effect on the wound.

The main objection to this procedure was the occurrence of urethral stricture, mainly at the meatus, which we found in the early series. However, since we have limited the indication as stated above, only a rare stricture has occurred, and this we feel is related to the indwelling catheter, since meatitis may occur despite all precautions, as an individual reaction to the irritating foreign body.

We have used the form of suprapubic prostatectomy in over 300 cases and we consider it a fine technic where an enucleation procedure is indicated.

45 East 85 Street

Radioactive Cobalt

"Radioactive cobalt emits a soft beta ray and two energetic gamma rays each over a million volts in energy. Cobalt-60 is used in a manner similar to that of radium: both for teletherapeutic purposes as well as for interstitial implants. Cobalt-60 has a 5-year half-life, is readily activated in neutron reactors from stable cobalt-59 and is available at a reasonable price. Sources of cobalt of 1000 curies and more are being increasingly used as external radiation sources. As a teletherapy source it has the advantage that no external wires are necessary which aids maneuverability, and that maintenance is simplified since there is no need for a power supply. The high energy of the gamma rays insures a relatively high depth dose distribution in the patient which facilitates effective radiation therapy. Cobalt-60 has also been encapsulated in needles and used interstitially in the same manner as radium needles."—John S. Laughlin, Sloan-Kettering Institute.

Trustees' Meeting, September 20, 1959

A regular meeting of the Board of Trustees was held at the Executive Offices in Trenton on Sunday, September 20, 1959. The actions taken are summarized below.

PUBLIC HEALTH STANDARDS

As a member of the Public Health Council of the New Jersey State Department of Health, Dr. Blaisdell presented for the Board's consideration and action the "Proposed Recognized Public Health Activities and Minimum Standards of Performance for Local Health Departments." The material has been in the process of compilation since 1954 by a group of competent men among whom were several physicians. It brings up to date high standards of performance and requirements in the administration of public health in New Jersey.

A public hearing on the proposals will be held in Trenton on October 8, 1959. Dr. Blaisdell recommended that the proposals be approved by The Medical Society of New Jersey, and that a letter, in the name of the President, indicating the Society's approval be presented at the hearing and read into the proceedings.

The Trustees approved these proposals and authorized the President to convey our Society's approval in a letter to be read at the hearing by Dr. Elias, our liaison representative with the State Health Department.

INTERPROFESSIONAL CODE

The interprofessional code has been adopted by the county societies of Atlantic, Bergen, Cumberland, Gloucester, Hunterdon, Mercer, Passaic and Warren. In Essex, Hudson and Middlesex it is under active study. However, the other ten component societies have not yet given it consideration. The Trustees instructed the Secretary to notify these ten societies of the actions already taken, urging these components to adopt the code.

INTRAVENOUS MEDICATION BY NURSES

On June 12, 1959 the N. J. Board of Nursing sent to all hospitals a memorandum on the subject of intravenous medication by nurses. Mr. Salvest, of the Attorney General's office, has stated that he sees no incompatibility between the statement of the State Board of Medical Examiners and the resolution of the New Jersey Board of Nursing. He feels that the matter could be resolved by another joint conference of interested organizations and agencies; and that the Board of Nursing would be satisfied if certain intravenous technics were included in the graduate training of nurses, provided that those who successfully passed such courses were given special certification.

It is the position of both this Society and of the State Board of Medical Examiners, that the prohibitory provisions of the Medical Practice Act (45:9-21) clearly do not apply to nurses acting under the specific direction of a regularly licensed physician. Such extra training, therefore, is beyond the requirements of present law and would be adopted only as a means to gratify the demands of the New Jersey Board of Nursing Examiners.

The most recent statement of the State Board of Medical Examiners was issued in August 1959 and sent to "All New Jersey Hospitals—Directors and Directors of Nursing Service," the substance of which was:

> In the opinion of the State Board of Medical Examiners of New Jersey, professional nurses may legally administer intravenous therapy and/or transfusions, provided that, in each instance, a written order for such procedures is recorded on the chart by a person holding a full license to practice all branches of medicine and/or surgery in the State of New Jersey — doctors of medicine and doctors of osteopathy. A physician need not be present during the conduct of the procedure.

The Trustees felt that it is a responsibility of our Society to protect its physician-members against the jeopardy in which they are placed in view of the present situation, and that this Board should now take the matter directly to the Attorney General. A resolution to that effect was passed.

SECTION ON PREVENTIVE MEDICINE

Dr. Kaufman as Chairman of the Committee on Annual Meeting informed the Board that both the chairman and secretary of the sec-

tion had resigned. The section, established in 1958 on the recommendation of the Special Committee on Industrial Health, met in 1958 with a very small attendance; and it did not meet in 1959. The Trustees voted to discontinue the Section without prejudice to the right to re-establish it when sufficient interest was manifested.

ACADEMY POLIOMYELITIS PROGRAM

In April 1960 the Academy of Medicine of New Jersey will present a symposium on poliomyelitis vaccination. The National Foundation plans to make this session the most important of its kind in the east in 1960. The Foundation and the State Department of Health have accepted co-sponsorship, and The Medical Society of New Jersey is invited to accept co-sponsorship. No financial obligation is involved. The meeting will be for physicians and lay persons interested in the development of vaccines.

The Chairman informed the Board that on August 24 he had granted tentative approval of the Society's co-sponsorship subject to confirmation by the Board. The trustees voted to confirm this action.

CONFLICTING ACTIONS BY COMPONENT SOCIETIES

A resolution from the Union County Medical Society with respect to the health care of the aged, was received by the Board May 17, 1959. It was tabled. Under date of July 2, 1959, this resolution was forwarded by the component society *to Medical-Surgical Plan and to Hospital Service Plan* with the statement that ". . . the Executive Committee of the Union County Medical Society discussed again the problem of medical care for our senior citizens and decided that we would be unwilling to accept any reduction in physician's fees unless a similar reduction in hospital fees was made by the Hospital Service Plan of New Jersey." The resolution and statement were received by the Board of Trustees of *Medical-Surgical Plan* at its July meeting. The representatives from the Medical Society had not known that the matter had been directed to MSP and HSP. This action taken by the component society was not understandable in view of the action of the 1959 House of Delegates referring the report on Health Care of the Aged "back to the Board of Trustees for further study *with power to act.*"

Dr. Bowers reiterated his statement made at the last meeting—Any medical organization that wishes to identify itself with organized medicine should not make policy decisions without at least first consulting the parent society which in this state is The Medical Society of New Jersey. He emphasized the need for unity on actions of the House of Delegates.

Following discussion, it was decided that the letter from Union County be acknowledged with the statement that the Board of Trustees is acting on specific instructions from the 1959 House of Delegates, and that if the component society wants action on its resolution it should be presented to the 1960 meeting of the House of Delegates.

SECTION ON NEUROPSYCHIATRY

A letter of resignation was received from the section chairman, Dr. Georges H. Lussier, who announced he would be out of the country at the time of the 1960 annual meeting. He recommended that the current section secretary, Dr. Thomas S. P. Fitch, be named chairman. The president of the N. J. Neuropsychiatric Association has recommended the appointment of Dr. William E. Ganss as successor to Dr. Fitch. The Board of Trustees voted to make these appointments.

ATLANTIC COUNTY SOCIAL SECURITY POLL

The following report was received from the Atlantic County Medical Society on the results of their poll on *Compulsory Social Security for Physicians*:

Number polled	119
Favor	69
Oppose	50
Now covered	33

BLUE CROSS REQUEST FOR RATE INCREASE

Dr. Featherston, at the request of the Chairman, had attended the hearing on August 25, 1959 with respect to the request for a Blue Cross rate increase. In his report, Dr. Featherston stated:

"After studying the several statements presented at the hearing, it is my considered opinion that The Medical Society of New Jersey, whether the increase is granted by the Commissioner or not, should ask for an intelligent appraisal of the situation in view of the statements made during

the session that hospital costs and Blue Cross premiums are very likely to increase in the foreseeable future (next year).

"On the committee for study, limitations should be sought both by more efficient Blue Cross administration and by less wasteful hospital administration. Nowhere did the proponents of the increase suggest any economy. The study committee should include Blue Cross, hospital administration, the Medical Society, labor, education, and above all the New Jersey Manufacturers Association, since a large percentage of the increase in costs will not be borne individually but will be passed on to industry.

"Lest the doctor be made the whipping boy for cost increases beyond his power to control, this study becomes urgent."

Subsequent to the report, the following suggestion was received from Dr. Featherston:

"The thought occurs to me that to protect the medical profession and The Medical Society of New Jersey, thought should be given to a wider separation of the policy of Blue Cross and Blue Shield. This must be done to prevent all the blame for increased costs from being laid in the lap of the medical profession.

"A good solution might be to have Blue Shield separate all officers who are also officers in Blue Cross—especially the public relations department as the first step."

Dr. Donnelly emphasized that in the past month publicity on medical costs has been most unfavorable; and in all of it there was little or no separation between hospital costs and medical fees. Along with this were statements by the President of Blue Cross, Mr. Withers, that the way to decrease hospital and Blue Cross costs was by Blue Shield riders to be sold in the future whereby diagnostic procedures could be done in doctors' offices or in the hospital outpatient departments. His statements were not cleared with any Blue Shield or Blue Cross official, and the public got the idea that doctors are sending patients into the hospital unnecessarily. There is a public relations counsel for Blue Cross and Blue Shield, but that department does not see Mr. Withers' releases. The salary of the public relations counsel is paid on the basis of 60 per cent by Blue Cross and 40 per cent by Blue Shield, while his services are rendered on the basis of approximately 99 per cent to Blue Cross and 1 per cent to Blue Shield.

Dr. Donnelly suggested that the Board recommend to the Board of Medical-Surgical Plan that Blue Shield engage its own public relations counsel who would report directly and only to the President and/or the Board of Trustees of Medical-Surgical Plan. A resolution was presented embodying this recommendation. This resolution was adopted and referred to the President and Executive Officer for editing. The President was requested to present the resolution at the meeting of the Board of Trustees of Medical-Surgical Plan on Tuesday evening, September 22, 1959. The edited resolution follows:

Whereas, in the past year—and particularly in the last month—there has been a great deal of unfavorable publicity regarding medical costs in New Jersey; and

Whereas, in all this publicity, it is never pointed out that although Blue Cross rates have risen some 15 per cent in the last year, physicians fees, under the Blue Shield contract, have risen only 12 per cent in the last ten years; and

Whereas, very little favorable publicity has been given to the Medical-Surgical Plan and its participating physicians and the contributions they have made in the last decade by limiting professional fees in the interest of controlling medical costs; and

Whereas, in all newspaper publicity regarding costs to the patient a distinct differentiation seldom is made between hospital costs and physicians fees; therefore be it

Resolved, that the Board of Trustees of The Medical Society of New Jersey recommend to the Medical-Surgical Plan of New Jersey that it hire its own public relations counsel, with salary to be paid completely by the Medical-Surgical Plan, who will be responsible exclusively to the President and Board of Trustees of the Medical-Surgical Plan; and be it further

Resolved, that the President of the Medical-Surgical Plan of New Jersey require that spokesmen for the Hospital Service Plan of New Jersey make no public statements regarding Blue Shield policies and contracts—current or proposed—except with the consent and approval of the Medical-Surgical Plan.

JOINT HEALTH CARE COUNCIL

In response to the Board's inquiry as to the possibility of the formation of a State Joint Council and the prorating of expenses, letters expressing interest or approval were received from the New Jersey Hospital Association, New Jersey State Dental Society, New Jersey State Nurses' Association, and Licensed Nursing Homes Association of New Jersey. However, all indicated no commitment of funds could be made without knowledge of the approximate amount involved.

The Chairman directed the replies be received as information at this time.

CHANGE IN MEDICARE

On July 28, 1959, a change was effected in the medicare program with regard to pregnant widows whose husbands died while in

active service. In the past the widow was required to turn in her identification form, and in exchange she received a new form confining her care to military sources. Under the change the widow will be authorized to receive care from civilian sources at Government expense if it is determined that she was pregnant on the date of her husband's death.

Dr. McCall moved—seconded by Dr. Bowers, and carried—that the supplemental agreement be accepted, and that the required signatures be authorized.

RADIATION PROTECTION

Chapter 116, P. L. 1958 (Radiation Protection Act) creates a Commission on Radiation Protection. A communication addressed to the chairman of the Special Committee on Industrial Health by the State Commissioner of Health invited him to submit suggestions relative to the formulation of those sections of the code pertinent to industrial applications.

It was the opinion of the President that representatives should be appointed to attend meetings of the Commission; and that the Commissioner should be informed of the proper channels for securing opinions and cooperation from the Medical Society, which is through the President or the Board of Trustees and not by direct communication to the chairman of any committee.

Dr. Schretzmann moved—seconded by Dr. Buchanan, and carried—that the chairmen of the Special Committees on Cancer Control (Dr. Olpp) and Industrial Health (Dr. Mitchell) be appointed as the official representatives to attend the meetings of the Commission to which they are invited.

The Board requested the President to inform the Commissioner of Health of the procedures established within the Society for cooperative efforts with outside organizations.

CONTACT LENSES AND OPHTHALMIC DRUGS

Two resolutions adopted by the 1959 House of Delegates were directed to the attention of the State Board of Medical Examiners. The first resolution, from Essex County, recommended that steps be taken to end the fitting of contact lenses and use of drugs by nonmedical personnel. The second resolution, from Cumberland County, recommended that the Society use every means at its disposal to bring about the prosecution and conviction of optometrists who use drugs or otherwise engage in the illegal practice of medicine.

In reply the State Board of Medical Examiners stated it was unable to take action of a general character in regard to the complaints submitted, but that the Board is willing to prosecute any individual or individuals who are violating the provisions of the Medical Practice Act, provided information adequate for prosecution is made available to the Board.

REPORT OF THE TREASURER

The $100,000 which was invested in short term Treasury notes has been returned to the general fund with interest amounting to $725. Permission was requested to invest $50,000 at this time in 90-day Treasury notes. The Trustees voted to grant such permission.

MEDICO-LEGAL TESTIMONY

Dr. Greifinger gave the following report of a meeting of the special committee on medico-legal testimony.

At an informal explanatory luncheon meeting with Chief Justice Weintraub, he promised to give careful consideration to our resolution regarding impartial medical testimony in courts when the medical testimony on the two sides is divergent. He also promised to bring the subject before the Judicial Conference in the fall, and to appoint a committee to study the whole problem. He also intends to bring the matter before the State Bar Association—with which group we have already been in conference.

Also discussed was the matter of malpractice suits against physicians. The Chief Justice declared that he would like to see a panel of doctors and lawyers established to examine malpractice cases to determine their merit. He was informed of our attempts to do this in the past and the reasons why it was not accomplished; and we assured him we would make another attempt if the Board so directed. The Chief Justice understands our problem with the insurance carrier and feels that we of the profession should make the final decision as to whether or not a case has merit.

This report was accepted; the special committee was instructed to continue its investigation.

WOMAN'S AUXILIARY PROGRAM

The 1959-60 program of the Woman's Auxiliary to The Medical Society of New Jersey was approved by the Executive Committee on July 13, 1959, which recommended concurrence by the Board of Trustees.

Dr. Allman moved—seconded by Dr. Buchanan, and carried—that the Board concur in the recommendation.

VA HOSPITAL FOR SOUTH JERSEY

There has been some talk of constructing a VA Hospital in the southern part of New Jersey. In this connection, inquiry had been made among members of our Burlington County Medical Society. It is now reported that this inquiry failed to find any support for the establishment of a Veterans Administration Hospital in South Jersey; it failed to find a single instance where the patient of a physician had to wait an undue length of time for admission to a veterans hospital. The members opposed the establishment of an additional Veterans Administration Hospital in South Jersey; and the hospitals within the Burlington County area concurred with the physicians. A copy of the report from the Burlington County Medical Society was forwarded to the federal legislative keyman who serves as liaison with Congressman Cahill, the sponsor of the bill for the construction of a VA hospital in South Jersey.

NURSE EDUCATION FOR CARDIAC CHILDREN

The Society's support was requested for a nurse education program on "The Cardiac Child" to be presented in December in Atlantic City. It has the support of the New Jersey Hospital Association and will be presented under the auspices of the State Department of Health, local nursing agencies, and the local chapters of the Heart Association. The Council on Public Health, to which the request was referred by the President, approved the proposed program at its meeting on September 10 and recommended that it be supported by the Medical Society. The Board now authorizes support of the program by The Medical Society of New Jersey.

ADVISORY COUNCIL ON EDUCATION

Chapter 104, P. L. 1959, concerning education for emotionally and socially maladjusted children, provides that an advisory council shall be appointed annually by the Commissioner of Education with the approval of the State Board of Education to advise in the promulgation of rules and regulations and other implementation of the act. The Medical Society of New Jersey has been invited to suggest names for appointment by the Commissioner to the advisory council.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried—that the Chairman and the President be authorized to submit nominations for appointment to the advisory council.

The following nominees were selected by the Chairmen and the President:

C. Byron Blaisdell, M.D., Asbury Park
Robert S. Garber, M.D., Belle Mead
Robert E. Jennings, M.D., South Orange
Vincent P. Mahoney, M.D., Camden

FORAND BILL

In reply to a telegram inquiry as to official developments and further steps to be taken with regard to the Forand Bill, the A.M.A. reported that the letter-writing efforts of the state medical societies were most successful and accomplished their purpose of demonstrating the unanimity of opinion of the profession with respect to Forand type bills. The A.M.A. will advise the state societies regarding the relative emphases that should be placed on the various elements that make up the over-all campaign.

COLLEGE BOND ISSUE

As President, Dr. Bowers was invited to serve as a member of the "Committee of 100 For The College Bond Issue." If he accepted his name would be on the committee's stationery and his support of the college bond issue referendum would be publicized. Dr. Bowers asked for the Board's direction.

The Board agreed with a response stating The Medical Society of New Jersey does not take any position in political matters not having a direct bearing on the standards or aspects of medical practice or the welfare and health of the people. Therefore as the Society's President he cannot accept membership on the committee.

UNITED NATIONS WEEK AND DAY

The President accepted an invitation "as a private physician" to serve on the Committee for United Nations Week (October 18-24, 1959) and Day (October 24, 1959). The committee requested the names and addresses of the Board of Trustees and county society presidents for the purpose of mailing informative literature.

Upon motion by Dr. Greifinger—seconded

by Dr. Kaufman, and carried—the Board authorized compliance with the request.

NATIONAL LIBRARY WEEK

Dr. Bowers reported he had accepted an invitation to serve on the New Jersey Committee under the chairmanship of Mrs. Robert B. Meyner. The week will be celebrated April 3 to 9, 1960.

AUDIT REPORT

The committee individually reviewed the report of the auditing company on the Treasurer's books for 1958-59, and earlier in the day the members met to discuss their findings.

The committee had no recommendations, and it was pleased to note that its recommendation of last year—that all investments be examined by the Auditor with the Treasurer—had been followed. The figures of the auditing company were accepted.

Upon motion by Dr. Allman—seconded by Dr. Blaisdell, and carried—the report was accepted.

RABIES VACCINE

The State Department of Health seeks the counsel of The Medical Society of New Jersey regarding the use of duck embryo rabies vaccine. The department currently provides the Semple vaccine and supplied 1,035 doses last year for the protection of approximately 75 persons presumably exposed to rabies. The Society's liaison with the Health Department, Dr. Elias, recommends endorsement of the use of duck embryo rabies vaccine as a public health measure. The Trustees voted to endorse this public health measure.

OTHER MATTERS

The Board of Trustees also voted:

—To send a letter of congratulation to Mrs. Paul E. Rauschenbach of Paterson, whose nomination to the State Division of the Aging was recently confirmed by the Senate.

—To approve Dr. Bowers' appointment as a member of the State Personnel Committee to select candidates for consideration by the National Credentials Committee in the selection of N. J. delegates to the 1960 White House Conference on Children and Youth.

—To accept with thanks the offer of Dr. Lancelot Ely, a Fellow of this Society, to present to The Medical Society, two very fine old books from Dr. Ely's excellent medical library.

—To name Dr. Phoebe Hudson as a second representative to the A.M.A. Conference on Physicians and Schools.

—To concur in the nomination of Dr. J. J. Torppey as our representative to the 1959 Diabetes Detection Drive co-sponsored by the N. J. Department of Health, the N. J. Diabetes Association and The Medical Society of New Jersey.

—To invite the American Medical Association to meet in Atlantic City in 1964, 1965 and/or 1966.

—To authorize the following to attend the 1959 Clinical Meeting in Dallas, Texas with expenses paid: President, President-Elect, Secretary, Executive Officer, and one Alternate Delegate.

—To approve a report of the Special Committee on the Conservation of Vision concerning the eye health program in the schools, including a recommendation of the Committee that the report thereon be published in brochure form and distributed to school personnel.

GOLDEN MERIT AWARD CEREMONY

193rd Annual Meeting

April 25, 1959

The Golden Merit Award Ceremony was convened at 3:25 p.m., Dr. Kenneth E. Gardner, President, presiding.

THE PRESIDENT: Officers and members of The Medical Society of New Jersey, Officers and Members of the Woman's Auxiliary, Honored Guests, and Beloved Recipients of the 1959 Golden Merit Award:

It is my privilege, as President of The Medical Society of New Jersey, to officiate at this, the third annual bestowal of the Golden Merit Award.

The Golden Merit Award was established in 1957 as an expression of The Medical Society of New Jersey's pride in, and affectionate regard for, those of its members who have completed half a hundred years as doctors of medicine. In bestowing this award The Medi-

cal Society of New Jersey honors itself by identifying itself with those distinguished men and women who have given a lifetime of devoted service to the people of New Jersey.

The growth of Medicine as a profession is measurable in terms of new research findings, new treatments, and new technics. Its greatness and its glory, however, spring from the constancy and selfless devotion of the men and women who make that growth possible and who bring to the bedside of their patients the benefits of the advances that are made. The practitioners of medicine are ministers of mercy who, with compassion in their hearts and healing in their hands, bring to the suffering sick whom they tend the hoped for peace out of pain. All mankind owes a debt to such as they. The Medical Society of New Jersey hopes in these ceremonies today at least to acknowledge some of that debt, which it can never hope to repay.

This year there are nineteen recipients of the Award. The total of their years of service is therefore nine hundred and fifty years, almost a milennium of unselfish devotion to the needs and welfare of their fellowmen. Certainly no tribute of service was ever more deserving of commendation and acclamation than theirs is. Certainly nothing that we do at this convention can be more important or significant than to tell these golden jubilarians, in the name of their profession and their fellowmen, how proud of them we are and how abidingly grateful.

Beloved Colleagues, we thank you for the gift which you have so generously made of your abilities and of yourselves. We thank you, also, for the inspiring examples of your lives, for truly by your life and work you have not only given health and vigor physically to those whom you tended, but you have enriched and ennobled the spirit and dignity of all mankind.

Joy be yours today, and for many golden years to come.

I understand that in the room at this time is probably our oldest member—Dr. Vroom of Bergen County. Dr. Vroom is 93 years old. (Applause)

At this time I'd like to introduce to you our Chairman of Public Relations, who is responsible for preparing this program today and who will announce the names for the awards —Dr. John F. Kustrup.

Dr. Kustrup: Dr. Gardner will present the awards from in front of the stage. Will the recipient, as his name is called, walk across the front of the stage with the marshal, who is the president of the component society? A photographer will take your picture at this end of the stage. So just walk slowly until the picture is taken.

(The awards were then presented by the President.)

The President: Thank you, Dr. Kustrup.

This concludes the presentation of the Golden Merit Awards. We are all very happy you could come. This is an outstanding occasion. We look forward to it each year because we are so happy to recognize these men who have given so many years of service to the practice of medicine. Thank you all for coming to this ceremony.

(The ceremony was concluded at 3:40 p.m.)

1959 RECIPIENTS of the GOLDEN MERIT AWARD

Bleasby, Charles B., Garfield

Butcher, Charles, Heislerville

Cody, Harry C., Bayonne

Edwards, James B., Leonia

Green, Albert D., Union City

Harvey, Thomas, W., Jr., Orange

Kelley, Charles N., Tenafly

Koplin, Nathaniel H., Trenton

Krauss, Fletcher I., Chatham

Maver, William, Jersey City

McLellan, George A., Sparta

Pendexter, Sidney E., East Orange

Rathgeber, Charles F., East Orange

Seiberling, J. D., Haddonfield

Sica, L. Samuel, Trenton

Tator, Arthur E., Summit

Thomas, Ralph B., Long Branch

Ulmer, D.H.B., Moorestown

Warren, Charles B., Ogdensburg

Open Discussion on Medical-Surgical Plan

193rd Annual Meeting

April 25, 1959

The discussion on the Medical-Surgical Plan of New Jersey was convened at 3:45 p.m., Dr. Royal A. Schaaf presiding.

THE PRESIDENT: We now have a discussion of the Medical-Surgical Plan. A distinguished group of gentlemen are here to make these presentations. I now introduce to you the President of the Medical-Surgical Plan—Dr. Royal A. Schaaf. (Applause)

DR. SCHAAF: Thank you, Dr. Gardner.

Good afternoon, ladies and gentlemen, and welcome to the open season on the Medical Service Administration and the Medical-Surgical Plan.

I would like first to present some of our staff—medical, administrative and legal. Dr. Nicholas Alfano, Executive Vice-President of the Medical-Surgical Plan. Next is Mr. J. Alfred Durgom, Vice-President and Executive Director of the Hospital Service Plan of New Jersey, who has done a terrific job in the past 18 years in the sale of our contracts, which have built up from 5000 the first year to two million people at the present time. Much of the sales appeal has been developed by Mr. Durgom. (Applause)

Next is Dr. Rothgesser of our medical staff. He has a great deal to do with the underwriting of our applications, particularly in the non-group enrollment. He serves the same function to the Hospital Service Plan. (Applause)

Next is Dr. Comando whom all of you know. For many years he was a Trustee of the Medical-Surgical Plan and the Medical Service Administration. He retired from the active practice of surgery a year ago and became the Medical Officer in charge of our physicians' relations program. It was pretty good before, but it really is excellent now largely because of the stimulus that Dr. Comando has given to it; and the enthusiasm and energy that he has devoted to the project. Dr. Comando. (Applause)

Next is Dr. Borsher who for many years was Medical Director of the Plan. He resumed private practice as a specialist in chest diseases and general medicine two years ago, and is now a Trustee of the Plan. I need hardly comment on the tremendous contribution which he made to the development of the Plan through some very difficult years. Dr. Borsher. (Applause)

Next is our eminent counsel who has shown us the way through many legal difficulties and on whose legal advice we place great dependence. He is the son of late Chief Justice Arthur T. Vanderbilt. He is William R. Vanderbilt, in his own right. Mr. Vanderbilt. (Applause)

And last but not least is our Administrator, Mr. John Robinson, who tends to many of the details of the office. Many of you have or will have contact with him if you have little problems. Mr. Robinson. (Applause)

In the audience we have the Administrative Secretary of the Medical Service Administration. Remember, we have two agencies. One is the mother or the parent of the other. We should give the Medical Service Administration precedence whenever we talk of the two plans.

Mrs. Nugent is back in the corner. I wonder if she'd take a bow. (Applause) I want to introduce Mrs. Jennings. She has been with the Medical-Surgical Plan since it began operations in 1942. She has made a tremendous contribution in the way of excellent direction of the office. (Applause)

MEDICAL SERVICE ADMINISTRATION

Now, to proceed with the Medical Service Administration. You have the report before you. It begins on Page 66, and there are general remarks about the Administration as it has been run. It operates the Newark Plan and it has been very successful in that for the last 15 years. In December 1957 the Administration became responsible for the administration of the Medicare Program. Up to December 31 last year, $1,267,000 had been paid for care of dependents of military personnel. All of that was handled through the Medical Service Administration. The details of the tabulation and the statistical work were handled by the Hospital Service Plan on a sub-contract basis.

The Medical Service Administration is an indispensable agency in the administration of the Medicare Program. It has been suggested that this program be taken over and administered by the Hospital Service Plan of New Jersey, but the Plan is unable to do that. It is not, under its enabling act, empowered to distribute medical care; it can distribute only

hospital care. Thus, The Medical Society of New Jersey could not directly engage the services of the Hospital Service Plan to carry on this work.

The suggestion has been made that the Medical Service Administration be detached from this work. If it were to be detached The Medical Society of New Jersey would have to develop some other mechanism for the conduct of the Medicare Program. It could either handle the program directly, which would be very costly to the Society in the matter of clerical help and so forth; or it could arrange for direct payments by the government, through Washington; or it could engage the services of a commercial insurance company to process the claims.

All this leads up to the fact that you will have before you for consideration at the session of the House, and I hope, approval by the Reference Committee of the request for the inclusion in the budget of $5000 for the continued support of the Administration if we find that it is necessary. This item has been in the budget for some years. We did not call for it last year and we didn't call for it for two or three years at intervals in between. We were obliged to do so this year; and because it was in the budget for the current year, the Trustees remitted the $5000 to the agency a week ago. But it is not in the forthcoming budget. I would urge your support for its inclusion after the Reference Committee makes its recommendation. I have no idea what they are going to do. I hope we can persuade them to make a favorable report on it.

Before leaving the Medical Service Administration I call attention to a change in the membership of the Board of Governors. Dr. Costello had been a Trustee for many years. He resigned last year and in his place Dr. Borsher was elected by approval of the Trustees of the Society and then by this body.

MEDICAL-SURGICAL PLAN

The Board of Trustees of the Medical-Surgical Plan—you note they have a different title—had several changes in the past year and a half. Dr. Costello resigned and was made an adviser to the Plan, along with other distinguished former Trustees.

We regretfully note the death of Dr. Corrigan on May 28th last year. He was replaced on the Board by Dr. Samuel Lloyd of Trenton. Subsequently Dr. Cuniff of Jersey City was elected, and Dr. Rickert of Denville, and finally Dr. Jerome G. Kaufman of Newark was elected in the past month. So you see we have four new replacements within a little over a year.

There has been some concern expressed in some quarters that the Board of Trustees is self-perpetuating and that a small group stay in office and that we are not enlivened by the addition of fresh brains and blood. But we do get it and these four men are surely going to contribute a very great deal to the enlivenment of our discussions. We are happy to have them.

Dr. Comando resigned a year ago and he is now with us as a consultant conducting the physicians' relations program.

Now, as you look over your report, you will notice the growth in annual receipts. In the last year the subscriptions earned were $29,228,537. Claims paid were $25,037,986. Our reserves have gone up moderately, but they may not continue to be in as satisfactory a state as they were.

All of you are aware of some problems we had last summer when the Commissioner of Insurance reduced our premium rates by five per cent across the board. That will impair our reserves if it continues. We made every effort to change the Commissioner's mind, but it was to no avail.

For a year and a half the Board has been working on expansion of benefits, including increased payments in several categories. We had a well thought out program which did entail the expenditure of two and a half million dollars per year in additional benefits. The Commissioner of Banking rather objected to this and wanted us to come in with a more modest proposal. But after long debate, the Board decided to put over the increased benefits effective October 1, at the time that the reduction in premium rate was made.

The annual report doesn't clearly indicate what happened. In spite of a reduction we felt that we were committed to the program because we had promised the participating physicians that benefits would be increased. We didn't feel that we could accept anything less than what we had promised.

The increases became effective on October First. We are not sure how it's going to affect our reserves. But before the end of the year it is probable that we will see a substantial reduction in our reserves. We may have to appeal to the Commissioner for an increase in rate at the end of this current year, which would be October 1, 1959. Whether it will be granted or not is another matter. I think that we can convince him that it is necessary to keep it going.

There are two major new items. One is the development of riders applicable to groups

only, which will extend the number of days of medical care available in hospitals. It will make available payment for any surgery which is done in the office at the same basis that it would be payable were it done in a hospital. It adds radiation therapy for proved malignant diseases to the amount of $250 in a contract year. It adds diagnostic radiology, done out of hospital to the amount of $100 in a contract year. It will offer clinical pathology, done out of hospital in the amount of $25 in the current year. Altogether it represents an expansion of benefits on a rider basis which in a way will have carried out the directives of this House of Delegates in previous years in which it was urged that the Medical-Surgical Plan make provision for payment to roentgenologists and clinical pathologists in the way they do to physicians, surgeons, obstetricians and other specialists.

We are working presently on a new basic contract which may include some of these benefits. We hope to include the out-of-hospital surgery. We hope to include some increase in the number of available medical days. We hope to eliminate from the present contract coverage for pre- and post-natal care out of hospital. That is one of our most difficult problems in our relations to the specialist obstetrician. We may be able to convince the Commissioner of Banking and Insurance that it would be in the interest of the subscribers to delete this inasmuch as many specialist obstetricians who are not now participating will become participating physicians and that should be a great advantage to the subscriber. We are dealing with very tough customers when we talk to the Banking Department and we can't promise you what will happen to this prenatal care problem.

The big unions—steel, automobile, railroads and similar bodies—want about the same coverage in sickness and accident insurance throughout the country. These riders were primarily developed to meet the demands of these national accounts. If we put them in effect, we will retain about ten per cent of our present business. If we don't put it in, we will lose some of these very valuable national accounts.

You are interested in the development of what might be called the "senior citizens" contract about which you were circularized a few months ago. We have an astonishingly favorable result from that questionnaire: sixteen to one in favor of a proposal which, in brief, would reduce the premium rate to about seventy per cent of the present contract rate and would bring about a reduction in benefits at about thirty per cent across the board. It might be a little less here and a little more there, but it would average around thirty per cent. The new schedule of benefits and the new premium rate are geared to a single person's income of $2000 a year and a husband and wife contract to $3000. The program will carry an adequate number of medical days in hospital and adequate coverage of surgery. There will be no obstetrics and no dependent care. The utilization will be more in the medical than in the surgical field.

It is, frankly, an experimental approach but it will work out, we think, satisfactorily. The premium income will be segregated for that category of cases. At the end of a year, if we find that the premium rate is too low to support it, we may have to ask the Banking Department for permission to increase it. On the other hand, if we find that we have collected more than we need, if the premium rate is within reasonable bounds, we could then increase the benefits or we could actually keep the benefits the same and reduce the premium. It is frankly, an experimental approach.

The riders we expect to have in operation on the first of July. The "senior citizen" proposals may take a little bit longer, but they are well along and the Plan thinks that it is going to be a tremendous contribution. It's not just a matter of the aged. When you get to be 65 you do not necessarily become unself-reliant and you do not necessarily become a public charge and you do not necessarily lose your self-respect; but it is going to do a great deal for the older citizens who are still enjoying reasonably good health.

QUESTION: Since the problem of the care of the aged seems to be the hospital cost, is there any proposal on the part of Blue Cross to go along with reduced premiums?

DR. SCHAAF: Mr. Durgom, will you answer that question?

MR. DURGOM: Unfortunately as of this date there has been no indication yet on the part of the hospitals of a method whereby there could be a lower rate of payment paid to the hospitals by Blue Cross in order to make possible coverage for the aged at a lower premium.

The Blue Cross is operating in its financial relationship with hospitals on a reimbursement formula. There is an increasing, rising cost in hospitals. How fast can Blue Cross meet these rising costs under the existing subscription rates, let alone having a lowered rate at the time being?

We had hoped at the national level of Blue Cross that there might be some leadership arising out of the American Hospital Association to its member hospitals, such as the AMA had indicated, some directional think-

ing in terms of the aged through the medical profession. But as yet nothing has developed. I couldn't make any statement that would commit the hospitals to such a program. We are hopeful that as the medical profession embarks on this program through Medical-Surgical, perhaps something can be found, some means, whether it be ward care, some modified rate for that limited type of accommodation.

Dr. Schaaf: Thank you, Mr. Durgom. And tell me, what is the present premium rate for a husband and wife contract?

Mr. Durgom: The present husband and wife rate under Blue Cross is the regular family rate because the Department of Banking and Insurance found the claim incidence extremely high. Husband and wife rate, the same as the family rate, is now $24.96 a quarter, which is a little better than $8.00 a month under the Blue Cross.

Dr. Schaaf: It's not quite a hundred dollars a year.

Mr. Durgom: Almost. And then if one had bought Blue Shield as the counterpart, that is at the present time at a lower rate because there is a distinction in the husband and wife rate compared to the family rate and that is only $10.92 a quarter. So as a result between the two it's roughly $35 a quarter; or about $120 a year.

Dr. Schaaf: Actually, though, the medical program would be a little less expensive. I think it would be around 70 per cent of the current premium rate.

Dr. Alfano: Last evening we received a report from our statistical department. Using the 1958 experience under the present contract and converting that to the contract as proposed for the over-aged and applying the schedule of benefits as proposed, which approximates a 30 per cent reduction in fees, the cost of the single subscriber contract would be about $1.95 per month. This, however, would include unlimited surgery out of hospital to the same extent as that provided in hospital, and medical care up to 120 days which is an increase over our present contract which provides 21 days per admission.

Dr. Schaaf: Getting back to the original question about what the hospital has done, the answer at the present time is that they have been unable to do anything specific but they are working on proposals for supplemental payments by the municipalities or the counties or something like that, that would enable them to carry it on a reduced personal payment.

Dr. Johnson (Trenton): This is a matter of mechanics. In an accident case where the patient is seen in the out-patient department of the hospital, let's say he incurs a physician's fee of $25 for a minor injury. He then has to come to the office. May he recover up to $50 from his Blue Shield in covering office visits? Some subscribers think they are entitled to coverage on office calls following an injury, up to $50.

Dr. Alfano: Originally as the contract was written, for the Plan to provide a payment of $50 in connection with an accident where the initial treatment was out of hospital, the services had to be within 48 hours of the accident. Later, we amended that provision so that even if the initial services were rendered in the out-patient department it would still provide the additional payments up to $50 for the after-care required for that one accident.

Dr. Johnson: In liability cases we are asked to keep our fees in line with the income of the subscriber. Suppose in court, a subscriber is awarded, say, $20,000. We are not permitted to increase our fees because that has been defined as non-taxable income. When we took this contract on, there was no definition of "income." Presumably, "income" means the amount of money received in a year. Why in liability cases must we conform only to taxable income in billing a litigant?

Dr. Schaaf: Before we wrote the 1956 contract we held a number of conferences with the orthopedic and traumatic surgeons. They, of their own accord, and we for them, studied the experience of the hospital and medical lien law in third-party cases. We found that the highest return under the lien law was 25 per cent and that was Beth Israel Hospital in Newark; and the same held true for the medical returns. If you don't get your hospital first, you don't get your medical.

Dr. Costello, who was at the time Medical Director of Dover General Hospital, where they have a great number of accidents on Route 46, had something like only 17 per cent of recoveries from liens. This representative group from the orthopedic and traumatic surgeons—felt that we should retain coverage in the contract.

You can't have it both ways. You have to put it in or you have to leave it out. If you put it in, then full coverage provisions obtain. If you leave it out, then the lien law applies. But then you can't recover from Blue Shield if you fail to recover from the third-party action.

However, if you turn to Page 75 of your annual reports, you will see that we are going to reconsider whether we should take it out

of the contract and not try to cover it. But again we will have to confer with orthopedic and traumatic surgeons who are most closely concerned with the problem.

The definition of "income" is a legal matter. Income is determined by the directives of the Commissioner of Internal Revenue. It has been ruled time and time again that returns from accidents or sickness insurance are not taxable "income." That's the only way the Plan could estimate taxable income.

There are many other factors in a verdict for a third-party action besides medical care. There is hospital care, nursing care and loss of income and many other segments of that payment. The amount which is actually available for medical care may not be large.

Dr. Johnson: Out-patient examination and diagnostic services have been made available to some national industrial labor groups on their insurance plan. The Medical-Surgical Plan of New Jersey has acted as a clearing house for these insurance plans. The exclusion of the private physician from benefits and allowances in such plans for such examinations and yielding them to hospital practice seems to encourage corporate practice. Do you feel that in cooperating as a clearing house that you might be working to the disadvantage of the private practitioner of medicine? I'm referring to such contracts as the United States Steel have where they may go to the out-patient department of a hospital and have barium enemas, or other gastro-intestinal studies. Sometimes Blue Shield has acted simply as the collector and disburser of funds and may do the paper work for such plan. Do you think that practice should be encouraged?

Dr. Schaaf: This rider coverage is not limited to national accounts. It originated because of the demand of national accounts but it must be available to any group. You can't sell it on an individual basis because the selection against the company would actually be too great.

We do not feel that, as this contract is set up, we will be infringing on the private practitioner of medicine. On the contrary we will be diverting from hospitals to the private offices of radiologists and pathologists, some practice which is now going to the hospitals because, by subterfuge, the patient is admitted to the hospital for diagnostic services to which he is not entitled.

Blue Shield and Blue Cross work very closely together on contract changes. What Blue Cross does affects us and what we do affects Blue Cross. No changes in either contracts are made without conference. We don't always agree, to be sure. There was a proposal to make available in out-patient departments x-ray and laboratory service by Blue Cross. The Medical-Surgical Plan objected to that and representatives of The Medical Society of New Jersey objected to the proposal. Everything that the Medical-Surgical Plan has done has been designed to advance the interest of the private practitioner and to diminish the amount of corporate practice of medicine by hospitals. For example, our radiation therapy is available outside of hospital and our diagnostic x-ray and laboratory service is available outside of hospital on these riders. Rather than infringing on the prerogatives of the private practitioner, they have been enhanced. We will be reducing the unwarranted and unjustified demands on the hospital plan.

Mr. Durgom: I confirm that, Dr. Schaaf. Through our coordinating committee, deliberations on new contracts for both plans, are looking to January 1, 1960 with some kind of a package program between the two plans for that purpose.

Dr. Schaaf: Blue Cross and Blue Shield both feel that hospitals should not compete with private practitioners. But there are certain areas where there are no available diagnostic services in private laboratories or x-ray services in private radiology offices. There you would have to have some some kind of modification. You couldn't be so arbitrary as to say they may never go to a hospital and so on. But the general principle will be to detach as much of this work as possible from the hospitals and channel it into the offices of the private physicians.

Dr. Harvey: Dr. Schaaf, I'd like to go back to the care of the aged. As I understand it, this is to apply only to those with an income of less than $2000. Is that correct?

Dr. Schaaf: The full coverage provision will apply to a person at $2000 or to a husband and wife at $3000.

Dr. Harvey: You speak about reducing the fees roughly one-third. What is this going to do in the way of setting a precedent for those people to expect to get office and home calls at one-third reduction? Will it have an effect on that?

Dr. Schaaf: I don't think it makes much difference. What we pay in the hospital doesn't affect the home and office very much, does it?

Dr. Harvey: I'm referring to the effect on the thinking of the patient. They feel that if they get one-third less in the hospital, they should get the same consideration in the office and home calls. I'm trying to figure out what was behind this idea other than being nice to old people. Heretofore we woud adjust fees according to their ability to pay. Has that

fallen down? Why has this come up? When Blue Cross can't see their way to reduce anything, why the doctors?

Dr. Schaaf: You have to think of hospital care and physician's care as separate items. Suppose a person cannot have any insurance, that he is paying his own hospital bill. A surgeon would give a much smaller bill to the person with $3000 than he would one with $10,000. The same with house calls. If you had a patient with only a $3000 a year income you'd be likely to charge him perhaps $5, where you charge $10 otherwise. You still control your fees quite within your own method of practice. I don't see that the scheme would do anything to change the present pattern of consideration given to people with lower incomes.

When it comes to the hospital plan, that's a different proposition because the *per diem* cost to a hospital is "X" dollars regardless of the person's income. It's very difficult unless, as Mr. Durgom suggested, some special arrangement were made for ward care at a lesser expense with contracting hospitals. That's something that is still in the future.

Dr. Harvey: I understand that, Dr. Schaaf, but what I was trying to get at is this. We are setting another wedge to lower the general level of fees. Unfortunately, every time we try to be good to the public and our fees go down, everybody wants it to become the standard level of fees. Heretofore we adjusted these fees according to people's ability to pay.

I know fixed rates keep the Blue Cross from coming down. But I'm not sure that the doctors shouldn't adjust the fees according to each individual patient rather than set an overall pattern that will set the precedent for other areas in the country. For example, the New York *Times* says the unions are complaining because Blue Cross wanted a little increase in fees. Apparently everybody wants to have better things and increased cost of living except the doctors. The doctors' attitude apparently is to pass it on to the other patients. There comes a limit to what you can pass it on to.

Dr. Gannon: Dr. Schaaf, I am not quite clear in my mind how the Medical-Surgical Plan proposes to pay benefits to those over 65 years of age. Most of the work will be in the field of internal medicine whether by an internist or general practitioner. There will be some surgery but no obstetrics, no pediatrics. There will be a lot of orthopedic surgery and perhaps, some time in the future, roentgenology. These fields will carry the burden of the aged. Do you propose to reduce those fees? Are you going to reduce all fees for all doctors and then have everybody share in this take care of the aged? Or are you just going to ask a certain group of physicians within the medical family to take care of this new idea?

Dr. Schaaf: Of course, we are operating under two levels of income and two levels of benefits. We are one of the very few plans that does not have multiple level contracts now.

What we will do when our contract is ready—it won't be before very long—is to send out preliminary drafts to every doctor in the state. We will send a participating physician's agreement so that we will know exactly who is willing to participate in the program and who isn't. The response to the original questionnaire was tremendous; it's about two-thirds of the total number sent out. When you get that response to a questionnaire it's pretty reliable. It was about sixteen to one. So arguing from that, it is fair to assume that we would probably have 80 per cent participating physicians in this program as now participate in the current program.

Dr. Gannon: Dr. Schaaf, I don't understand yet what you are going to do. Suppose that you pay $5 for a certain service in internal medicine. Do you propose now that you are going to reduce it a third to $3 without changing the fee in pediatrics? Or are you going to reduce all fees in medicine to pay for this?

Dr. Schaaf: The lower fee will apply only to people who are insured under that particular contract. It will not affect pediatric fees; it will not affect your current medical fees under the standard contract.

Dr. Gannon: But I thought Medical-Surgical Plan was based on the idea of having everybody pay for these services. That would seem to me to be the reason for this. Why would you take one group of people and say here, you carry the burden? Why should I have to keep the solvency of the Medical-Surgical Plan for a pediatrician? That's ridiculous. He should carry it the same as I should.

Dr. Schaaf: Well, don't forget this, that with multiple level contracts and multi-level premium charges you buy greater benefits with larger premiums and smaller benefits with smaller premiums. Your benefits are geared to the income of the people and the premium rate is geared to the income of the people, but everybody whose income is below $3000 for husband and wife would be entitled to full coverage with the lesser fee. People whose in-

come is over that would have to pay the premium rate for the higher contract and they would get the higher benefits.

Dr. Gannon: Dr. Schaaf, it seems to me the way the problem should have been approached was to go to the labor unions, go to everybody that's interested and say: Look, we have to take care of elderly people and it costs so much. We propose to raise the rates of everybody and then we will let the elderly people have these cheap contracts, but you, society, is going to pay for it. Instead of that, you are proposing that Medicine should do it. Now I find to my chagrin certain small groups of medicine are going to pay for it! Those who practice internal medicine, those who practice some forms of orthopedic surgery and a few others, whereas the others are going to have all their gravy and not contribute at all. Yet you tell me all these people voted for something, but it seems a little bit odd that a person who is not going to be affected should vote away the rights of someone that is affected. It seems to me something is very wrong again.

Dr. Schaaf: Tomorrow you are going to be at the Reference Committee meeting. I'll be there and I'll be glad to argue it.

Dr. Henry J. Mineur (Union): How much will a couple save under this new benefit in a year's time?

Dr. Schaaf: Mr. Durgom said that it would be about $1.95 a couple per month, which is $23.40 a year. The present rate is, husband and wife, $10.92 a quarter now, and the rate then would be less than $6.00.

Dr. Mineur: So the couple would save approximately $20 a year, is that right? Well, how is the word "income" going to be defined for this contract? Many retired people have very large non-taxable, non-reportable income. Now, let's get our definition before we sign the contract rather than get clobbered afterward.

Dr. Schaaf: The people who would be covered by this are people who will be living on Social Security. By and large that will be their sole income. There will be some others who might be chiseling, to be sure, but then that's when the doctor comes along. He knows if they are driving an automobile and living in a nice home and they've got television and radio and so on, it's a fair assumption that they've got more income than that.

Dr. Mineur: I beg to differ with you, sir, because we are bound by our contract.

Dr. Schaaf: Only up to $2000 or $3000, as the case may be.

Dr. Mineur: I'm talking about the current contracts where we have no way of knowing. A man may have a very sizeable annuity income that is non-taxable and non-reportable. Is this "income?"

Dr. Schaaf: No. There is only part of that which is "income" and that's about a quarter. If you've got a 30-year endowment it's about a quarter of that which is taxable income; the other is money he saved. It isn't income at all.

Dr. Mineur: Yes, but does that mean that we are bound by taxable income or by actual income?

Dr. Schaaf: Taxable income.

Dr. Francis A. Merlo (Union): We had quite a discussion about the questionnaire that was sent out. We felt that you hadn't given us enough in the questionnaire for us to answer that honestly. Most of the men just signed it and sent it in, hoping that at a later date you would give us more information. Now, all you did was ask us if we were in favor of that.

Dr. Mineur is telling you about the man with a great deal of money, but his only "income" is Social Security. He has got a lot of cash left over that he can leave to his children. Well, we give him cheap visits and good care for cheap prices. Because of that, we in Union County felt that your questionnaire was very unfair. It caught us by surprise. To that extent we passed a resolution, and it was unanimously adopted, that no questionnaires would be answered by anyone in our county unless that was brought up at a previous meeting and discussed by our county first. I don't think your questionnaire gave us enough. And I don't think the vote of sixteen to one is a fair vote because you just sent out a feeler and now you are using it as a final vote.

Dr. Schaaf: No, Doctor, no. The question was this: The American Medical Association at its meeting in December urged that something be done very promptly. We got telegrams from the American Medical Association and from the Blue Shield Medical Care Plans: What will you people do?

Well, now, unless you have been working on the development of contracts, you have no conception of the enormous amount of time and effort that has to be devoted to a statistical study and what it costs the Plan to do it. So before undertaking to spend time and money on something which would turn out to have been a futility, we wanted to know whether there would be enough support to even undertake an approach to it.

You did not get a letter asking you to sign a participating physician's agreement. Had

we done that you would have a just cause for complaint; you would have a just cause for the resolution which apparently you signed and which this is my first knowledge of.

Before we adopt this contract you will know what the premium rate is, what the benefit schedule is and you will have an opportunity to sign or not to sign a participating physician's agreement. If you haven't signed it, you will not be bound by the provisions of the contract.

Dr. Joseph: We are all told to read the fine print of a policy or contract. But many of us don't have time to read the fine print and those of us who do sometimes don't understand it. For instance, not one person out of a thousand knows what you mean by a "non-contract hospital." He goes in there very innocently as a patient and he is taken care of and then at the end of the week or the month he is penalized to the tune of five dollars per day because that particular hospital did not subscribe to your contract. I don't know what Blue Shield has to pay to a contract hospital as against a non-contract hospital. But I wondered if Mr. Durgom has made any attempt to see what effort is being made to have these non-contract hospitals become contract hospitals. Patients are being penalized for not knowing that they are entering a non-contract hospital and not told so at the time.

Mr. Durgom: Doctor, we are trying to reach the point of perfection. On the point you have raised—and you are correct—we have had exchange of correspondence. You were talking about two per cent of the plans, over two million patient days a year that are served and we would like to cover those two per cent not only as obtains to a few hospitals in New York but throughout the country. We have now 147 hospitals under contract. It costs nothing to any of these hospitals to enter into contract so far as payment of any fee is concerned. They agree by this instrument of understanding, on the reimbursement cost program. We intend to meet their "Manual" costs on the basis of a Manual agreed on with the hospitals. Now, there are a few in New York, particularly the so-called high area hospitals, that have not entered into a contract with the plan. They are in the Inter-Plan Bank Program throughout the country. They, too, do give service benefits at the level of the New York Blue Cross Plan. That leaves only those who have no contract with our plan and no participation in the bank, and that's the two per cent we are speaking about.

But the one that you are talking about is the one where it does participate in the Inter-Plan Bank. Unfortunately these Blue Cross plans, the 83 across the country, are not uniform in their benefits. There is an area of difference in benefits between New York and New Jersey. As a result, in going into such a hospital in New York and being limited to the level of benefits in the New York Blue Cross by reason of its contract and its subscription rates there is a little less benefit made available.

Now, we are hoping at the national level of Blue Cross through the Blue Cross Association to be able to establish a uniform program of benefit. That is in the making.

Dr. Joseph: Thank you. Now I would like to say a word about Dr. Comando's new post and perhaps he and his associates might be able to do something about this. Originally, you remember, Blue Cross and Blue Shield were started primarily to avoid nationalization of the medical profession, more or less.

Dr. Schaaf: Mostly less.

Dr. Joseph: Well, mostly less, yes. But the point is that having done that we are willing to try to keep down the fees for people subscribing to either Blue Cross or Blue Shield. The fees are constantly going up and might price themselves out of the market. That's a possibility. And the other possibility is that we might kill the goose that laid the golden egg. I'm talking now about the doctors.

I cautioned a man in our hospital ten years ago that if he insisted on sending people into the hospital to have a little lipoma and a little something or other, a sebaceous cyst removed —if they turned a case worth $25 into a case that's going to cost Blue Cross or Blue Shield $150, it's going to kill the entire business.

Under Dr. Comando's command, so to speak, would it be possible to get a survey of how many cases they have admitted to their hospital, which would be considered by any of us as "minor" cases? Why were they admitted? They tied up beds for patients who needed beds very badly in the hospital. That is why hospitals are building additions today: in many instances because there are many patients admitted to hospitals who should never be there and never were there before.

If the doctor responsible for admitting such cases to the hospital persists in doing so, might he not be cautioned by the county society? That would be a very important item. I don't know of anything constructive that's ever been done about that. This is very vital for the existence of the Blue Cross and Blue Shield, and also for the matter of fees con-

cerning the charges on Blue Shield and Blue Cross.

Dr. Comando: Dr. Joseph, I think you put your finger on the key to this problem. Blue Shield cannot control the practice of medicine. The policing must come in the individual hospital itself and from the State Society. We are trying in an educational way to work with advisory groups of the county societies to the Plan and sending people around to the hospitals for the very purpose that you have in mind. But it is very difficult for the Plan to try to tell a practicing doctor what is a hospital case, and which one should go in and which one should not go in. In the very busy hospital where there is a pressure on beds, they have done something about it. They have committees on admission and discharge. Several hospitals have done a very, very good job.

Some hospitals have a low occupancy, and sometimes the administrator is not averse to having these cases go in. But it is certainly something that is not in our hands; it's in the hands of you gentlemen and, of course, you can give the Plan and funds a hard time. We are helpless. We are in your hands.

Dr. Joshua M. Zimskind (Trenton): In reference to that questionnaire, my impression and everybody else's impression that I spoke to in Mercer County was that it was difficult for older people to become members of Blue Cross or Blue Shield, and we all felt that it was a good idea that they be allowed to do it. The impression we had was that they would come in as members. Their expenses would be thrown into the general pot and there would be no cutting of fees or cutting of anything else, the hospital rates or fees, by admitting people over 65 into this plan.

I'm rather surprised to hear you bring up the idea that they were going to come in on a cut-rate basis. I don't think it's necessary. I am sure that the sixteen to one vote meant that everyone who had ever been associated with older people, thought they should certainly get it when they were entitled to it. But I don't think there was any question about reducing rates provided they paid for the insurance. If the whole group were polled on the thing they would say that all these people should be taken in just like infants are taken in, same as older people are taken in and be pooled in the whole group and the rate set for the whole group as it is.

For a year or so, until you find out how much the thing costs, you might be at a loss to begin with, but I don't think there was any idea in anybody's mind that this was going to cut either the hospital rates or the physicians' fees.

Dr. Schaaf: This idea emanated from the American Medical Association. The action taken by the Plan was at the behest of the American Medical Association, Blue Shield Medical Care Plans, Incorporated, and The Medical Society of New Jersey.

Now, I don't think that we can argue the merits of a two-level contract because that has been established. Almost every Blue Shield Plan in the country has it. We were unable to get permission to write a multi-level contract. We tried it for years with the Banking Department and it's only in response to this public demand that we did come up with a lower premium, lower benefit contract. I think that everywhere else but in New Jersey they recognize the validity of multi-level contracts.

Dr. Nathan S. Deutsch (Union): We are all agreed that, to forestall the Forand Bill or the Morse Bill or any number of bills in Congress, we have to take a positive approach to the care of the aged. We don't seem to be in agreement as to the mechanics of the solution. In Union County, we passed a motion condemning The Medical Society of New Jersey for the way it tried to survey our county. We are a component society. We *are* the A.M.A. The A.M.A. and The Medical Society of New Jersey are pre-empting the functions of the county societies. Things like this should come from below.

When the Medical-Surgical Plan was put in effect it was given to the county societies for full and open discussion. If you had done this, you also could have had all this debate in our component societies and not have lost too much time. We could have come to a good solution on it.

The point just stated by Dr. Gannon and Dr. Mineur and the others is that it wouldn't be right to penalize half of the doctors to cover the load of the other doctors in the plan to take care of the aged. Some plan should be formulated in which all of us would share the cost.

Dr. Schaaf: Doctor, I think we should clarify something. In the first place, the questionnaire was not sent out by the Medical-Surgical Plan of New Jersey. It was sent out by The Medical Society of New Jersey.

Dr. Deutsch: I said that, Dr. Schaaf. I meant that.

Dr. Schaaf: But others seem to think that it was sent by the Blue Shield Plan. It was not.

Dr. Elbert H. Pogue (Union): It is my understanding that the original Blue Cross

and Blue Shield programs were not set up to prevent the nationalization of medicine, but rather to furnish a means of getting needed medical and hospital services for those who were potentially medically indigent. However, I have heard on many occasions and with some first-hand knowledge know that the ceiling level on the income of subscribers has been gradually raised from $2500 at the inception of the plan to $7500 on a family basis at present.

Now, in this plan for the aged we are starting off with a $2000 to $3000 level. What assurance do we have that it will remain at such a level? It has been my unhappy experience that we seldom come out ahead in a game when the rules can be changed in the middle of the game and you have nothing to say about it. That is the situation here.

DR. SCHAAF: Well, I hate to contradict you, but that is *not* the situation here. In the first place, you left out a very major portion of your original premise, and that is that although the income level has gone up, the benefits have gone up enormously. All you have to do is compare the schedule of payments under the $2500 limit and the payments under the $7500 limit.

And you don't change the rules in the middle of the game. You have to write an entirely new contract because the Banking Department won't let you change them. If you don't want to increase the income level or you don't want the benefits reduced, you can object to that, and no benefit schedule has been adopted, either to increase or diminish it, without consultation with and confirmation by The Medical Society of New Jersey.

DR. MURPHY: I believe that here in New Jersey we have a daily rate, more or less of an average, that each hospital receives from Blue Cross. Is that true, Mr. Durgom?

MR. DURGOM: The rate varies with each hospital, based on the hospital's financial experience on its overall operations.

DR. MURPHY: That's right; but it runs somewhere around $20 to $22 a day, somewhere in that neighborhood.

MR. DURGOM: No, it's running in the average now a little over $27, nearly $28 a day as a weighted average rate across the State.

DR. MURPHY: All right. If I go to Arkansas and get hurt and the Arkansas Blue Cross only allows $10 a day and I pay the New Jersey rate, will the Arkansas hospital get the average for New Jersey or will I, as a subscriber, only get $10 a day toward my Arkansas bill?

MR. DURGOM: If that hospital in Arkansas is in the Inter-Plan Bank you will get inclusive services at the level of the Arkansas hospital's relationship with its local Blue Cross Plan, but you will get the number of benefit days under your New Jersey contract.

DR. MURPHY: Which means I get $10 times 21.

MR. DURGOM: Well, 120 days.

DR. MURPHY: All right, 120 times $10 then.

MR. DURGOM: I'd like to qualify that. The $15 rate of payment by New Jersey Blue Cross to a non-contracting hospital is only if that hospital in Arkansas is not in the Blue Cross program at all. Then you'd get $15 indemnity. That's the two per cent I spoke about in response to Dr. Joseph's question a while ago.

DR. MURPHY: Why wouldn't I get the usual average for New Jersey? Say I'd get $20 a day toward my bill, why do I get penalized? I'm paying New Jersey rates, not Arkansas rates.

MR. DURGOM: That's a good question, Doctor. Let me clarify that, if I may. You pay a premium rate in the New Jersey Blue Cross Plan for what is known as a pre-payment program whereby you understand that if you enter certain hospitals, meaning hospitals under contract with the Jersey Plan or in the movement, you will get inclusive services. Therefore, you never know in advance when you might need to go in the hospital, and once in the hospital you never know what your total bill is until you are out. But if you leave without making any payment to the hospital, then your question becomes academic, doesn't it, because you had full coverage.

DR. MURPHY: When I'm in Arkansas it doesn't become academic. The balance on the bill is, shall we say, a hundred or two hundred dollars, yet I don't get as much benefit as I would if I were staying in New Jersey.

MR. DURGOM: Have you a specific case where somebody went to a hospital in Arkansas and had to pay out of pocket, Doctor?

DR. MURPHY: No, but I have a specific case in some other state.

MR. DURGOM: Well, in any state the test is simply this: That it's academic if you went to a hospital that's in the Blue Cross movement because you get inclusive service benefits.

DR. MURPHY: Well, that a little technical.

DR. ANTHONY P. DE SPIRITO (Monmouth): I'm a pediatrician so I'm not concerned with this obvious inequity, but I'd like to ask Dr. Comando a question about the problem of policing ourselves and admitting patients who, we know, do not need hospitalization. This should be carried one step further. The conscientious physician does not want to admit

a patient to the hospital. He is, in most of these cases where we have these admission, being forced to by the patient. It's not the physician's fault.

We should try to discourage the patients from asking to go to the hospital for obvious diagnostic work and little things that the doctor was talking about.

Has some sort of fifty dollar or a hundred dollar deductible policy been worked on, which might be the answer to many of our problems?

Dr. Schaaf: I think Mr. Durgom would probably tell you what happens when you apply a deductible. Supposing that you deduct the first two days, then they stay 9 instead of 7 days. Will you amplify that, Mr. Durgom? So you don't save anything by the first two days being deductible. Is that correct?

Mr. Durgom: I'll try to answer that briefly. You are correct, Dr. Schaaf, that there is not, in the long run, any saving in all of the attempts across the country among Blue Cross plans to try to meet this problem of excess utilization by incorporating some kind of a co-insurance or co-payment deductible arrangement. It's been found in some plans that where there were first two days, for example, eliminated from plan benefit, whereby the patient would be responsible for that payment, that that patient as a class, shows a longer length of stay because they stay on the other end of their period of required stay. It's just an element of human behavior.

By the same token, where you have a $50 deductible in terms of a monetary elimination from plan benefit, whereby the patient pays that $50, such as in the instance of automobile insurance (from which the idea was borrowed) there again you find no control because there is at the other end the ordering up of more services to get their money back, so to speak.

Unfortunately when we are dealing with co-insurance or co-payment by eliminating like the first couple of days or eliminating the first $50 or $25, whatever it be, it's not like in an automobile insurance policy because if the automobile has collided with another car the impact has already caused the damage and the first $50 deductible is deducted. Motorists don't decide: let's smash into each other. They don't say: let's make it a little bigger because we have to pay the first $50. But in the case of human behavior in the hospital it is where a person might find they want to remain.

Now, we are getting more and more experienced in this "major medical" in that direction. They have incorporated deductibles, but to meet the catastrophic area on the other end needs up to now some further adjustment.

In the Blue Cross now, as Dr. Schaaf indicated, there have been studies in progress between Blue Shield and Blue Cross in our coordinating program of activity. We recognize in Blue Cross a need for a lower priced contract for those who may not want all of the services in the comprehensive level of benefits that we now sell. Now, we are only selling the comprehensive benefits, frankly, because that is what the market is demanding in this present inflationary economy. But there are people, we believe, who would want to pay less; therefore, to do that, rather than go to hospitals and ask them how we can produce a lower rate, since we are now hoping for something to be done about the aged for that, and that hasn't yet been done, we are thinking in terms of a co-payment on the part of the patient of so much per day beginning with the first day and all through the length of stay of that patient. We are hoping that this might be the answer. But there again we don't know that it will be because while it will be new in some sense in New Jersey, we have found some traits of this particular program already offered. For example, in Cleveland they found that there was practically no market for it because people don't want to buy it.

Dr. Henry J. Konzelmann (Union): It seem to me that many of those cases that would have to pay a deductible fee would not go to the hospital for minor things that would cost them less than the deductible. For example, if a patient has a cyst removed, that can be done for $25. It would cost them $50 if they had a deductible fee. You might eliminate many patients who would not go to the hospital because of those minor conditions. You would have a decrease in the number of cases going to the hospital for these so-called cysts and small operations that you are talking about in the first place.

Dr. Schaaf: They will be taken care of to a large extent when we increase, as we hope we may in the new basic contract, surgery in office at the same rates that we pay in the hospital.

Dr. Konzelmann: I have something here a little different and not an argument with you fellows, but I have a list of suggested fees on the use of isotopes in treatment and diagnosis, for your consideration. I wonder where I should submit these so they could be considered.

Dr. Schaaf: If you will give it to Dr. Alfano, we'll be very glad to take it under advisement.

Dr. Schell: I have always been interested in the differences in per diem rates across the

state. When there is a difference of six to eight dollars a day in the same city, between two hospitals, there has to be some reason for it. Is a hospital's per diem rate determined by the overall cost of that hospital's operation, taking the number of beds it has, dividing it into the total number and then coming up with a basic figure? It costs so much per day to handle a patient, is that correct?

MR. DURGOM: Not conclusively, Doctor. It doesn't work quite that simply. But your impressions are correct in that we are influenced solely by the financial experience of that hospital. So we take the income and expenses of that hospital; that gives us total figures in and out. At the same time there are adjustments in our "Manual" of allowing so much towards depreciation, so much for improvements, replacement of equipment, what not, as we go along, so much to take into consideration for the medical center aspects of that hospital in terms of research, so much in terms of the nursing school, if it has one, so much of an adjustment as a result of out-patient in relation to in-patient.

In other words, these two hospitals that you might speak of in the same community may not be necessarily identical. They may have the same bed capacity, but there again from the internal operations of the hospital we, too, get baffled wondering why there is a spread of as much as three or four or five dollars a day between the two hospitals; yet when we go into it through the independent accountants we find that the method of professional practice in one hospital differs from that in another hospital. In other words, standards are a little different. I don't mean standards in quality of medical service but rather standards in terms of the professional practices. So we are faced with all of those conditions and as a result in New Jersey today we have a spread of *per diem* rates to hospitals ranging from $16 a day to $32 a day.

DR. SCHELL: Hospitals carrying the large indigent load always have the lowest per diem rate. That spread in our county amounted from a maximum to a minimum of over $6 a day. It's inconceivable to me that a hospital taking care of the indigent could be penalized; that is, could operate, let's put it, with economy to the extent of $6 cheaper per day for a private patient than a hospital across town which is handling only private patients. If this hospital were to eliminate its wards, convert that space into private rooms its *per diem* rate would go up. Its return from Blue Cross would have to go up because the cost of operating that hospital as an entity would go up.

That hospital, as far as I'm concerned, is subsidizing that Blue Cross contract and subsidizing it to a considerable degree. It is holding up the community which will not support the indigent. It's supporting medical education through the only means it can—by taking care of the indigent and for its trouble gets the lowest possible *per diem* rate in the community. There is something wrong with this and your adjustments, whatever they are, are inadequate, grossly inadequate.

MR. DURGOM: I appreciate your frankness and I shall try to make a frank comment. Your observations would lead us to believe from what we know in the Plan to be the exact opposite of your premises, and the only way I think that can best be resolved is first consider that the financing of the indigent is not the responsibility of the Blue Cross. It is not included in these financial calculations in arriving at a *per diem* rate. Responsibility for the financing of indigent care is one between the hospital and its community relationship with its government and it's been on that basis throughout the years of Blue Cross that this particular concept has been carried forward; and in fact there has been quite widespread concurrence even including a former president of the AHA.

If you know of any specific hospital you presumably have in mind where you think this is working in the reverse of what I've just mentioned, I would be very happy to have you and any of the medical staff, together with the administrator of the hospital come and visit our headquarters and, with the permission of the hospital, there showing all the data. You will find that it works just in the opposite direction from what you have been led to believe to be the case.

DR. SCHELL: Well, this resulted from a private investigation of my own. I went to each administrator, myself, in the entire county. I had to take the figure that they gave me as their *per diem* rate. If anything, it would have been lower. There would have been no sense in lying about making it higher than it was. And so I accepted it as true.

Is it not true that when you evaluate the *per diem* cost for the care of a private Blue Cross patient, you evaluate that *per diem* rate on the basis of the overall operating expense of that institution, whether it be three-quarters ward or one per cent ward, one per cent indigent or 75 per cent indigent. You calculate into the overall *per diem* rate for the private patient the cost for the care of the ward patient, is that not so?

MR. DURGOM: Not quite, Doctor. The *per diem* cost to the average hospital is about the

same, within a few pennies across the board, between ward compared to semi-private compared to private.

I think that the point of concern that you have, and it's a correct point of concern, is when you are dealing with charges of hospitals. Charges are not what we are dealing with in our basis of payment to hospitals. Charges have a necessary loading by necessity of the method of operation of a voluntary hospital. Somebody has to pay for the free care.

I'm thinking of a particular hospital which receives from its freeholders $6 a day for indigent care. The actual *per diem* cost to that hospital is around $22 a day. Somebody has to pay the difference between the $6 advanced by the freeholders and the actual $22 cost to that hospital; that's a $16 differential. The only hope that hospital has for any recourse is to load its charges sufficiently.

We can't pay charges because it would be contrary to a fact-finding firm basis of payment to a hospital. So we suggest that the hospital not be concerned with Blue Cross over its so-called write-offs (which is the difference between Blue Cross *per diem* cost rate of payment and the hospital's loaded charges)—I mean "loaded" in the sense of having that extra weight added to it—it would be the practical thing for the hospital to get more supporting income from its freeholders, or whatever the arrangement would be.

There has been some very definite advancement in that direction within the last several weeks. Freeholders of several counties are now taking up this problem because it practically ties in, Dr. Schaaf, with the problem of the aged in a sense because they are either medically or financially indigent or both.

Dr. Schell: Well, then this analysis that you present—you say you have some very definite figures on what it should cost to care for a patient in a hospital in a particular area.

Mr. Durgom: I didn't say what the cost should be. We have a fact-finding way of knowing what the cost turned out to be. We can't tell a hospital how to administer itself nor go to medical staffs and say there should be a change in procedure. We have facts from an independent accountant on the basis of certified data in actual evidence on the records of the individual hospitals. Those are the data that we'd be very happy to make available through proper channels.

Dr. Sol Gurshman (Middlesex): In these riders will there be anything about house calls? Some of the plans in New York and some of the private plans permit a certain number of house calls. They allow a certain fee. The patient has to pay the difference between that fee and the doctor's fee.

Dr. Schaaf: The answer is no.

Dr. Gurshman: Are you going to make it so that one has to be a *bona fide* surgeon or roentgenologist in order to take x-ray pictures? I mean a surgeon who has his boards or one who has his boards in radiology.

Dr. Schaaf: The question has not been finally settled. It may not be settled until the Banking Department rules on it. Our own opinion is that under the contract we would have to pay whoever rendered the service. Talking now about clinical pathology and x-ray.

Dr. Gurshman: To take x-ray pictures in a doctor's office, must one be a roentgenologist?

Dr. Schaaf: I think under our contract anyone would be eligible, unless the Banking Department changes it.

Dr. Gurshman: X-ray men may try to change it.

Dr. Schaaf: They may try. I don't know. Under the contract I think whoever took the pictures would be eligible.

Dr. Gurshman: Instead of circularizing some of the traumatic surgeons and the orthopedic surgeons, there are some of us who are just doctors and we are called the general practitioners. Why not circularize everybody in the state insofar as third-party suits and double contracts with two or more insurances?

Dr. Schaaf: We consult the obstetricians on obstetrical problems and we consult the surgeons on surgical problems and we consult the internists on internal medical problems. And while any doctor may be practicing in any of those other fields, we have to be guided by what might be called the expert testimony of the people who are closest to the work. While the general surgeon and general practitioner may do fine traumatic surgery, that's not his principal line of work and we feel if we get the opinion from the orthopedists and traumatists that it is the best guide we could have and we do that to set the fees and to establish the practice.

Dr. Gurshman: I might mention one thing about these old aged. We are not speaking about the indigent; they are taken care of. But the medically indigent are not taken care of. I had a patient in the hospital just seven days and her bill was $150 for the hospital. Now, the doctor's bill according to the Medical-Surgical Plan, if she were in it, would only be $40 for that week.

Dr. Schaaf: Well, in the 21 days now eligible under the contract, it's possible to get $110.

DR. GURSHMAN: I'm just giving this as an example of a person who does not have medical and hospitalization. The doctors' fees are the least; it's the hospitalization fees that are ruining these people.

DR. GULLORD: For the last few years this meeting has been held primarily for the House of Delegates; that is, it is held before the regular meeting of the State Society. We call this the Medical-Surgical Plan, the Doctors' Plan. I think it is a meeting that everyone in the State Society that has interest enough to come to the State Society meeting should have an opportunity of attending. I'd like to suggest to you people that this meeting be turned back to the times it used to be, during the course of the regular meetings of the State Society rather than just be available to delegates who are here ahead of time.

DR. SCHAAF: I'm in complete accord with the suggestion. We take the time that the administration of the convention set up for us. It has to do with the conflict with the general sessions and with the sections and this and that. As far as I'm concerned, it's immaterial if we have it the first or the last day; and the more people who have an opportunity to participate in the discussion, the better we like it.

Thank you for coming.

Obituaries • • •

DR. ANTHONY CICCONE

Dr. Anthony C. Ciccone, a Paterson internist, died on October 6 at St. Joseph Hospital where he was chief of medicine. Born in Paterson in 1896 he was graduated in 1921 from Fordham University Medical School. He returned to his native city and served the people of Passaic County as a private practitioner from 1923 until his death last month. He was, for many years, an active member of the Paterson Board of Health. He served in many capacities in the Passaic County Medical Society and was president of the Paterson Italian-American Circle. He was also active in the affairs of St. John's Cathedral.

DR. EDWARD M. RIZZOLO

Dr. Edward Rizzolo of Belleville died on September 21, 1959. Born in Newark, Edward Rizzolo interrupted his college career to enter our Army in 1917. On being demobilized, after combat duty in France, he finished college and then entered the medical school of Baylor University from which he was graduated in 1925. He interned at St. Michael's Hospital in Newark and then opened an office in Belleville. He served the people of the Belleville-Nutley-Kearny area for more than 30 years. Dr. Rizzolo was active in civic affairs in his adopted town and was a member of the Essex County Medical Society. Dr. Rizzolo was 61 years old at the time of his death.

DR. ROSTIN WHITE

Dr. Rostin White, senior surgeon at the Shore Memorial Hospital in Somers Point, died at his home near Naples, Florida, on September 5. Dr. White was born in 1901 and was graduated in 1925 from the Jefferson Medical College. He was a F.A.C.S. He became associated with the Shore Memorial Hospital in 1932 and eventually became president and chief surgeon of the institution.

Dr. White was a member of the local Board of Education as well as a medical inspector for the public schools. He was active in the affairs of the Atlantic County Medical Society, also in the work of the Association of Military Surgeons. He served in the Medical Corps during World War II.

DR. NATHAN ZVAIFLER

Dr. Nathan Zvaifler, one of New Jersey's pioneer bronchoscopists, died on October 18 at the age of 65. Born and raised in Newark, he received his M.D. degree in 1917 from the Jefferson Medical College. He interned at St. Michael's Hospital in Newark and then did graduate work in Austria. He became interested in ophthalmologic and otolaryngologic surgery and won certification by both Boards. He was an F.A.C.S. and a member of the New Jersey Society of Surgeons. He was also affiliated, in either a consultant or attending capacity, with Martland Medical Center, Presbyterian Hospital, and Irvington General Hospital.

Announcements • • •

Booklet on Educating the Epileptic

Now available gratis is the booklet *Educating Children with Epilepsy*. Written by Dr. N. G. Haring, the brochure describes the diagnosis of the different types of epilepsy, and the problems of educating the epileptic child. The booklet is obtainable from the Federal Epilepsy Association at 1729 F Street, N. W., Washington 6, D. C.

I. C. S. Elects Jerseyites

Dr. Harry Bacon of Philadelphia has been named president-elect of the International College of Surgeons. Dr. David B. Allman of Atlantic City and Dr. Earl J. Halligan of Jersey City are among the newly-elected vice-presidents.

White House Conference on Aging

By act of Congress, a White House Conference on Aging will be held in Washington in January 1961. The immediate responsibility is that of the Federal Department of Health, Education and Welfare. Former Congressman Robert W. Kean of New Jersey has been named chairman of an advisory committee which will be responsible for the general planning and preparations of the Conference.

The several states will be asked to hold local conferences on aging in order to develop an agenda for the 1961 conference. It is anticipated that the White House Conference will result in the development of specific recommendations to be sent to the President of the United States.

It is anticipated that the Conference will cover the physical, economic, emotional, housing, social and vocational aspects of growing old.

A National Leadership Training Institute was conducted in June 1959 at the University of Michigan. Doctors Eckstein, Hahn and Buchanan of New Jersey and Mr. Richard I. Nevin attended the Institute with Dr. David Eckstein as chairman of the New Jersey delegation. This Conference discussed methods of fact-finding and of surveying our resources. The meeting included a workshop on State surveys which analyzed the mechanism of investigating these problems. There was also a discussion of public relations and how to disseminate information on the subject.

Practical examples of what good community planning could do were recited. The chairman of the New Jersey Medical Society's delegation felt that organized medicine, including especially the county medical societies, should speak out on this subject. There is some concern about the plan to give the Federal Government stewardship over the lives of 15,000,000 people over the age of 65. It was important, our delegation felt, that we communicate to the public the idea that the medical profession and its affiliate professions are willing to cooperate by helping maintain the health at all levels of the population.

Stein-Leventhal Syndrome

The Stein-Leventhal syndrome is manifested by oligomenorrhea, hirsutism and polycistic ovaries. This is now being studied by the National Institute of Arthritis and Metabolic Diseases in Bethesda, Maryland. Doctors who have such patients on their rolls, are asked to notify Dr. J. F. Rall, Chief, Clinical Endocrinology Branch, National Institute of Arthritis and Metabolic Diseases, Bethesda 14, Maryland.

N. J. Officers of A. C. of Gastroenterology

Several New Jersey physicians were elected to office in the American College of Gastroenterology at its meeting in September 1959. Dr. Theodore S. Heineken, Glen Ridge, was named vice-president, and Dr. Louis L. Perkel, Jersey City, was elected secretary. Another physician to be honored by the College was Dr. Earl J. Halligan of Jersey City, who was re-elected governor.

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society* held September 15, at Bergen Pines, Paramus, was called to order by Donald B. Hull, M.D., President, at 9:07 p.m. There were 44 members present.

The Secretary read a memorandum dated June 4, from The Medical Society of New Jersey, reporting actions by the House of Delegates at the Annual Meeting on resolutions received from the Bergen County Medical Society: (1) Nursing Homes for the Aged and Chronically Ill—Disapproved; (2) Health Care of the Aged—Disapproved; (3) Social Security for Physicians—Adopted.

The President summarized the situation regarding the issuance of M.D. license plates by the State Motor Vehicle Division. One of our members suggested that the members of this Society "boycott" the M.D. plates. R. E. Verdon, M.D., presented the following resolution which, after slight revision, was adopted:

Whereas, M.D. license plates were issued originally as service plates for Civil Defense purposes, following World War II, and

Whereas, the Division of Motor Vehicles of N. J. now places M.D. license plates in the same category as low numbered courtesy license plates, and,

Whereas, There is no evidence of a meeting of representatives of the Division of Motor Vehicles and The Medical Society of N. J. prior to classifying M.D. plates as courtesy plates, now therefore, be it

Resolved that the Bergen County Medical Society record its opposition to the placing of M.D. tags in the same category as special low numbered courtesy license plates, by the Division of Motor Vehicles and be it further

Resolved That the Bergen County Medical Society urge its members to refrain from requesting M.D. license plates.

The Chair directed that copies of this resolution be sent to each Bergen County hospital for posting on bulletin boards, and that it be published in the *Bulletin*.

Mr. David Blanksteen, representing E. & W. Blanksteen Agency, Inc., of Jersey City, the insurance agency which carries our group accident and health insurance spoke about the group life contract now being offered, stating that only nineteen additional applications were needed from members of this Society to effect coverage for all applicants regardless of insurability. He urged that each member carefully consider acquisition of this excellent protection at the earliest possible date.

Before turning the meeting over to Dr. S. B. Reich, Chairman, Program Committee, the President introduced the following guests of the Society present at the meeting: Miss Gertrude Eckhardt, Executive Director, Mrs. Margaret R. Osterman, Supervisor, Division on the Aging, and Mrs. B. P. Galanti, First Vice-President and Chairman, Committee on the Aging, all of the Bergen County Tuberculosis & Health Association.

Dr. Reich then presented Dr. George M. Warner, Executive Director, Home Care Department, Montefiore Hospital, New York City, who spoke on "The Practical Problems in the Care of Older Patients."

Dr. Irving M. Levitas, Chairman of the Committee on the Aged and Chronically Ill, asked the speaker at the conclusion of his presentation to discuss briefly "What in his opinion the Committee on the Aged and Chronically Ill of a county medical society can do toward solving the problems presented by the speaker." Dr. Warner made some suggestions and Miss Eckhardt discussed the survey conducted by her organization. She also expressed her deep appreciation to the members of the Health Committee, all of whom were members of this Society, for their invaluable help to her Association.

CHARLES P. CAMPBELL, M.D.
Reporter

Burlington

The first regular meeting of the *Burlington County Medical Society*, with President Edward Haldeman presiding, was held at the Millside Farms Dairy Bar, Riverside, September 10. Our guest speaker, Dr. Herbert A. Luscombe, Chief of Dermatology, Jefferson Medical College, discussed "The Diagnosis and Treatment of Superficial Fungous Infections." This clear, lucid talk reviewed for us the diagnosis of the common skin fungal infections, and evaluated for us the impact of the new drug Griseofulvin in their treatment. It is exciting to hear of one more stubborn group of diseases yielding to specific chemotherapy.

Part of the business meeting was devoted to discussing the United Fund of Burlington County. The problem was presented by Mr. James Barker, an officer of the Fund. The Fund has in its two previous years failed to collect the necessary monies for the charities it has sponsored. Exception has been taken to the methods of solicitation. Some have felt that the costs of administration and collection consumed too large a proportion of funds collected. Our Society voted to withhold sponsorship, as a Society, of the United Fund.

Drs. John Gallagher and Gordon N. Lockhart were unanimously elected to the society, as transfers from the Philadelphia County Medical Society.

Winfield Betts, M.D., described the elaborate de-

fense display to be held this month at the County Administration Building, including first aid and rescue work, demonstrated most convincingly simulated casualties. The meeting was adjourned at 9:55 p.m., setting an enviable record and precedent for the new year.

LINDLEY B. REAGAN, M.D.

Reporter

Gloucester

The *Gloucester County Medical Society* met on September 17 at the Woodbury Country Club. The meeting was presided over by Dr. Dorothy M. Rogers, President.

After approval of the April meeting minutes, Dr. Hammell Shipps, attending gynecologist at the Cooper Hospital and assistant clinical professor of obstetrics and gynecology at Jefferson Medical College, gave an informative talk on gynecology in general practice. The discussion by Dr. Shipps was warmly received.

Subsequently, the business session was opened by reading the minutes. Treasurer's report was rendered by Dr. George Booth. Plans for the coming fall social session were discussed. Dr. William Beall reported on the activities of the Cerebral Palsy Clinic in Glassboro. A change was made in the rate of annual dues and it was decided by unanimous vote that the dues be raised to $100 per year to include the county dues, state AMA dues and also the AMEF fund. In addition, this would include a fee for the annual banquet.

The meeting was then adjourned as all members agreed to meet on October 24 once again, at the lovely setting of the Tavistock Country Club for what is certain to be a most enjoyable evening.

WILLIAM D. KEHLER, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on October 6. Dr. Charles E. Rosen presided.

Guest speaker of the evening was Mr. Ardell T. Everett, Second Vice-President of The Prudential Insurance Company of America. Mr. Everett's topic was "Federal Health Insurance and the Private Practice of Medicine." Many doctors participated in this discussion.

Reports were read from the Diabetes Committee and the Constitution and Bylaws Committee. There was a discussion of the M.D. license plate problem. In view of recent developments it was stated that members should use their own discretion in the purchase of the special plates.

Drs. Stuart S. Stevenson of East Orange and Mario J. DeBari of Hoboken were elected to membership at this meeting.

Following the business meeting a collation was served.

ROY A. MORROW, M.D.

Reporter

Mercer

103 members were present at a regular meeting of the *Mercer County Component Medical Society*, held October 14 under the chairmanship of its President, Dr. John A. Kinczel.

Announcement was made of the deaths of Dr. David B. Ackley (a past President of our Society (1906), Emeritus Member, and recipient of the Golden Merit Award), passed away June 14; Dr. Wilbur Watts (a recipient of the Golden Merit Award), passed away August 12; and Dr. John B. Comfort, a past President of our Society (1926) passed away August 27.

Action taken at the meeting included:

Adoption of the budget for the year 1960.

Acceptance of report of Nominating Committee.

Election of the following physicians to membership: Active—Drs. Roscoe P. Kandle, Marion Makohin, and Robert G. Proctor; Associate—Clifford J. Alloway, Alfred D. Christie, Howard N. Epstein, Dietrich Hartert, Raymond M. Kostrzewa, Genuino Nazzaro, Donald R. Reisfield, Mary A. Rorro, Richard Siegler, and Thomas M. Williams.

Physicians elected to membership during May and June (were introduced to their fellow members: Drs. Robert S. Albahary, Hans W. Freymuth, Rudolph C. Gering, James B. Hastings, Vito F. LaFranco, and August S. Rivero.

A motion was passed that a committee be appointed to give full consideration to the initiation of a comprehensive rehabilitation plan for Mercer County. Our Program Committee was asked to consider the suggestion that future programs be varied, rather than limited to those of a highly scientific nature.

A motion was passed that the Mercer County Component Medical Society assume the leadership in the establishment of a Community Blood Bank.

Note: Since preparing the foregoing report, we have been informed of the death of Dr. Lawrence H. Rogers, Medical Director of Donnelly Memorial Hospitals of the City of Trenton since 1925, who passed away October 14. Dr. Rogers, a past President of the Mercer County Component Society (1920) was the recipient of the Golden Merit Award in 1958.

RALPH N. CAGAN, M.D.

Reporter

Monmouth

Dr. Lester Barnett, the newly-elected president of the *Monmouth County Medical Society*, conducted the Society's regular meeting on September 23, at Monmouth Medical Center, Long Branch.

Elected to Active membership were: Dr. Martin Alperin, Dr. Harold Chafkin, and Dr. William A Kaloss, Middletown; and Dr. Gilbert Meltsner, Oakhurst. Associate membership was granted to Dr. Houshang Hakim, Asbury Park and Dr. Hilliard C. Gersten, Oceanport.

Dr. Bernard Halbstein, Long Branch, was elected to the Judicial Committee to complete the unexpired term of Dr. Frank Altschul who resigned.

The following resolution was offered by several school physicians: "That the Monmouth County Medical Society urge school authorities to adopt the requirement of immunization against diphtheria, poliomyelitis, and smallpox as prerequisites for school attendance." The resolution was defeated by a show of hands.

A report on the questionnaire mailed to physicians on compulsory inclusion of physicians under Social Security was made. Three hundred and thirty-six questionnaires were mailed to the membership. In favor were 98; opposed were 137; one was undecided.

The president urged support of the Medical Student Loan Fund and the American Medical Education Fund.

The Hon. John E. Toolan, Perth Amboy, former New Jersey State Senator, addressed the Society on "Medical Malpractice." Accompanying the guest speaker was Judge Cecil S. Ackerson, Keyport, who commented on the topic at the conclusion of the talk.

LEONARD S. DANZIG, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on September 15 at 9:00 p.m. at the Medical Society Building. The President, Dr. Julian Cohen, presided.

The following were elected to Associate Membership: Drs. Herbert Staniszewski, Edwin J. Pear, William A. Dwyer, Leonid Tzibrouk and John M. Campbell of Paterson; John W. Bromley of Glen Ridge, Robert D. Cerfolio of Hawthorne, Philip J. Jasper of Passaic, Norman S. Hersh of Wayne, Peter M. Masley of Clifton and Richard W. Rado of Butler. Elected to Active membership was Dr. John S. Winston of Paterson.

Resolutions on the deaths of three members of the Society, Dr. Francis L. Stouter, Dr. A. Andrew Kennedy, and Dr. Albert J. Blake were adopted.

A report of the Finance Committee was read for the fiscal year ending May 31, 1959, with its recommendations concerning the amount of dues for 1960.

On motion, the report and recommendations of the Finance Committee were approved as presented. The October issue of the *Bulletin* will contain the complete report.

The subject of M.D. license plates was discussed. M.D. plates were created originally as a civil defense identification measure and not as a special privilege for physicians. A letter of objection will be sent by Dr. Cohen to the Governor and the Acting Director of the Motor Vehicle Department.

A motion was adopted to accept the inter-professional code between physicians and attorneys which was published in full in the August *Bulletin*. This code has already been accepted by The Medical Society of New Jersey and the American Medical Association.

Dr. Cohen read a letter from E. & W. Blanksteen stating that 31 more applications are needed from our Society in order that policies may be issued to the impaired risk cases in Passaic County which have thus far been rejected.

The meeting was then turned over to Dr. Louis Chodosh who introduced the guest speaker, Samuel L. Feder, M.D., Assistant Attending Psychiatrist, Mount Sinai Hospital; College of Physicians and Surgeons. Dr. Feder spoke on "Psychiatric Emergencies in General Practice." A question period followed.

IRVING CHRISMAN, M.D.

Reporter

Salem

The *Salem County Medical Society* held its first meeting of the new term on September 18 at the DuPont Penns Grove Country Club with the incoming president, Dr. George A. Nitshe, Jr., of Elmer, presiding.

Mr. Vincent Brown of the Hospital Service Plan of New Jersey, was introduced by Dr. Ford C. Spangler, program chairman. He outlined new enrollment contracts available, and discussed difficulties which arise from time to time. He emphasized the continuing study being made to resolve these problems. In a question and answer period, members had individual problems regarding Blue Shield policies discussed and clarified.

The Society adopted the Interprofessional Code as it applies to members of the American Bar Association and the American Medical Association. In conjunction with this code, a medical-legal liaison committee was approved with Dr. Nitshe to name the committee.

Elected to the nominating committee were Dr. Charles B. Norton, Dr. Isadore Lipkin and Dr. Harry W. Fullerton, Jr.

Dr. John T. Dooley was accepted for membership in the Society.

The Eye Health Screening Program in Salem County was again conducted at Salem County Memorial Hospital with Dr. J. Robert Cox of Penns Grove as chairman.

A county-wide educational program on tetanus immunization sponsored by the Salem Jaycees with Dr. William Sprout as chairman, is in progress.

The aim is to secure maximum protection against tetanus infection in all age groups. Dr. Sprout requested help of members in tabulating the number of immunizations in this area.

G. F. REICHWEIN, M.D.

Reporter

New Jersey Orthopaedic Society

The Spring Meeting of the New Jersey Orthopaedic Society was held at the Hackensack Hospital, on Saturday, April 11th, 1959 with Dr. Robert J. Neville as program chairman and moderator. This was a combined "traumatic and orthopedic clinical day" at the Hackensack Hospital in conjunction with the Spring Meeting of the New Jersey Orthopaedic Society. The guest of honor was Dr. William B. Estes, President of the American College of Surgeons.

The Morning Session, arranged by the Orthopedic and Traumatic Surgery Department of the Hackensack Hospital, was devoted to the surgery of trauma in the emergency room. Dr. Spencer T. Snedecor, Director, presided at this session.

The guest of honor, Dr. Estes, made a presentation on non-penetrating abdominal trauma. Dr. Estes spoke about his interest in trauma and surgery in the American College of Surgeons, presented comments on the approach to the treatment of multiple trauma and also of abdominal trauma.

The Morning Session was completed by an inspection of the Emergency Room facilities at the Hackensack Hospital conducted by Dr. W. C. Rucker.

The Afternoon Session, arranged by the New Jersey Orthopaedic Society was conducted by the program chairman, Dr. Robert J. Neville.

This part of the program included presentations on epiphyseal displacement, flexion-extension injuries of the spine, fractures of the neck of the femur and chondrosarcoma. This was followed by a business meeting of the New Jersey Orthopaedic Society with Dr. Keith E. Haines, its president, in the chair.

R. J. NEVILLE, M.D.

Program Chairman

Book Reviews • • •

Long Term Illness. Edited by Michael G. Wohl, M.D. Philadelphia 1959. Saunders. Pp. 748. ($17.00)

The conquest of so many acute diseases has converted most medical practices into care of the chronic. In the past, this was a neglected area. It is becoming, however, a major field of medicine today. In this big book, 75 experts contribute concise chapters on as many different fields of long term illness. The spectrum runs from gout to leukemia, from allergies to alcoholism. There is a chapter on drug addiction, and one on chronic disease in childhood. There is a section on chronic emotional illness and a chapter on rehabilitation in general to which is appended a list of rehabilitation centers in North America. Also included is material on nursing care, on hospitalization for long term illness and on home care. The book is down-to-earth in its approach, with treatment or management methods explicitly spelled out.

ULYSSES M. FRANK, M.D.

Diseases of Women. By Ten Teachers. Under the direction of Frederick W. Roques, M.D., Baltimore, 1959. The Williams & Wilkins Co. Tenth Edition. Pp. 556. ($8.00)

The title, *Diseases of Women by Ten Teachers*, does not do this book justice. The list of "teachers" resembles a roster of Who's Who in Gynecology in England. This is the tenth edition of a book that was published for the first time in 1919. It was produced originally for medical students and has been brought up to date every few years.

This book embraces the usual gynecologic subjects in a systematic and thorough fashion. It starts with the anatomy and embryology of the female genital organs. It is complete in its discussion on hormones in gynecology and covers menstruation from both a physiologic and pathologic standpoint. The book covers the latest developments in cytology. There is a good section on sterility which includes the factors involved from a gynecologic standpoint such as x-ray procedures,

artificial insemination and investigation of the husband.

It is interesting to note the different and sometimes strange sounding names of drugs used by British physicians. One can surmise that these drugs are similar to ours by the way in which they are applied to therapy.

A whole chapter is devoted to surgery including pre-and postoperative management and surgical complications. Many operative procedures are discussed. Some are illustrated. Time and space naturally limit the amount of discussion and the number of illustrations. Though not meant to be a surgical text, the book does touch on the most frequent surgical problems in gynecology.

There is a very interesting chapter on "neurasthenia and neurosis in relation to pelvic disorders" which, of course, is an important factor in gynecologic complaints. All in all, it is a worthwhile addition to any gynecologic book shelf.

VICTOR HUBERMAN, M.D.

New and Nonofficial Drugs, 1959. Council on Drugs of the American Medical Association. Philadelphia 1959. Lippincott. Pp. 687. ($3.35)

Most of us have come to rely on the release of *New and Nonofficial Drugs* every spring for providing a map through the jungle of newer drugs. This year's edition omits monographs which have previously appeared or which have been admitted to the *Pharmacopeia*, such as amphetamine and thiamine.

The prochlorperazines represent a conspicuous addition to the 1959 issue.

The book includes conversion tables to and from the metric system and a list of official and regulatory agencies. The bulk of the book, of course, is made up of monographs. These run the alphabetical gamut from anesthetics to vitamins. For each item there is a list of indications and contraindications.

HENRY A. DAVIDSON, M.D.

Hypertensive Disease, Diagnosis and Treatment. By Sibley W. Hoobler, M.D. Hoeber-Harper, New York. 1959. Pp. 353. ($7.50)

This excellent text, aimed at the practicing physician, describes the step-by-step management of the hypertensive patient. It is well written, and gains from single authorship by an individual well-versed in his field, and able to write fluently. Dr. Hoobler first describes hypertension susceptible to "complete cure," including hypertension of renal origin, pheochromocytoma, hypertension of adrenocortical origin and coarctation of the aorta. Detailed aspects of the proper diagnostic evaluation and treatment of these types of hypertension are included.

The second section deals with secondary hypertension not susceptible to "cure," and describes the palliative management of these diseases. The bulk of the book is devoted to essential or primary hypertension. These chapters deal in detail with the natural history of both the "benign" and accelerated forms. The author describes the treatment of primary hypertension without and with the complications of congestive cardiac failure, cerebrovascular disease, renal disease, and coronary insufficiency.

A wonderful series of chapters dealing with the pharmacology of chlorothiazide, the rauwolfia alkaloids and mecamylamine, along with criteria for surgery is included. Case histories with comments are interspersed throughout the text. The appendices describe various tests for the different varieties of hypertension as well as the emergency treatment of hypertension.

This book should be on every practitioner's desk, as a handy reference work to the management of a most common and difficult disease.

MAURICE J. ZIMMERMAN, M.D.

Anatomy of the Nervous System. S. W. Ranson, M.D. and S. L. Clark, M.D. Ed. 10. Philadelphia 1959 Saunders. Pp. 662 with 434 illustrations. ($9.50)

This old reliable is now in its tenth edition. The book clarifies the complex but vital subject of neuro-anatomy. The illustrations are clean and clear. In its last hundred pages, the book includes a practical laboratory manual. The chapter on clinical aspects of neuro-anatomy is useful and lights up the importance of a mastery of anatomy to any clinician. A chapter on embryology is brief but adequate. The cross sections of the brain in the back of this book have been famous for decades, and on reviewing them, I find them as usable as ever. All in all, a superior neuro-anatomy!

HERBERT BOEHM, M.D.

An Atlas of Normal Radiographic Anatomy. By Isadora Meschan, M.D. and R. M. F. Farrer-Meschan, M.D. Ed. 2. Philadelphia, Saunders. 1959. Pp. 759 with 1446 illustrations. ($16)

Eight years have passed since the publication of the first edition of this fine atlas. It proved its usefulness not only to technicians but more important to the student and resident in radiology to whom the line drawings together with the radiographs provided a means of learning the normal roentgen anatomy.

The current, revised and enlarged second edition has retained and improved on this material and has added sections where recent work has warranted such additions. A most important chapter on radiation protection has been included. Bone growth and development material has been re-

written in the light of recent concepts. New illustrations and the introduction of Log Etronic prints have increased the visual value. "Cardiovascular radiography" in all its facets has been enlarged upon in the light of recent advances.

Certainly a valuable book has been made more valuable and it deserves a place in all radiologic libraries.

CARL KNITZER, M.D.

Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D. With the collaboration of 80 contributors. Philadelphia 1959. Saunders. Pp. 1462. Ed. 7. ($16.50)

Six earlier editions of *Nelson* have been so well received that there would seem to be little occasion for repeating the previous praises heaped on this text. This edition includes new material on eosinophilia, pulmonary ventilation, handling the hadicapped child and behavior problems. Milton Senn has tried to cover emotional problems in 30 pages. There is an interesting section on preventive pediatrics. A 16-page table of drugs and doses will be found so useful that pediatricians might want to have the pages photocopied and kept under the desk glass. The book makes a conscientious effort to cover the entire field. Most of the chapters are solid in content if somewhat pedestrian in style. However, with 81 contributors, there is considerable variation in readability. The book includes many useful tables, charts, diagrams and illustrations.

RALPH N. SHAPIRO, M.D.

Insulin Treatment in Psychiatry. Edited by Max Rinkel, M.D. and Harold Himwich, M.D. New York 1959, Philosophical Library. Pp. 386. ($5.00)

In 1958 a conference was held on insulin treatment. This book was made up pasting together the lectures delivered there together with some of the discussion. The editors failed to remove duplications and overlap. Some of the material, particularly on the early history of insulin therapy, is repeated. We are given in enormous detail the results of this therapy in Argentina and in Peru. Many of the authors are politely cautious about the effectiveness of insulin. Others are enthusiastic. Dr. Hoff says that insulin is "the only successful biological treatment." He also finds a disturbance in pyruvic acid in *all* cases of schizophrenia. The book itself opens with the astonishing statement that epilepsy was the first psychotic manifestation recognized in man. (It's a strange book on psychiatry that starts chaper 1 by calling epilepsy a psychosis!). A hundred pages are devoted to hormonal and biochemical studies of the brain under insulin, though not related to corresponding clinical events.

The tribute to Manfred Sakel is well deserved. Dr. Sakel was one of the few men in history who actually contributed a brand new technic—a rare event in any century. Insulin treatment for schizophrenia was born in 1933. Most (but not all) psychiatrists believe it started to die by 1953 and that it must now be considered obsolescent. This book will be valued as a historical monument rather than as a clinical guide.

FELIX A. UCKO, M.D.

Elementary Statistics with Applications in Medicine. Frederick Croxton, Ph.D. New York 1959. Dover Publications. Pp. 376. Paper. ($1.95)

A Primer of Statistics for Non-statisticians. Abraham Franzblau, M.D. New York 1959. Harcourt Brace. Pp. 150. ($3.50)

Clinicians have finally—if somewhat reluctantly—come to realize that medical research cannot reach full flower without the validation that only statistical technics can give. Few physicians, however, are at home in a world of chi squares, indices of correlation and standard deviations. These two books aim to fill the need. Dr. Franzblau is a physician interested in statistics. Dr. Croxton is a statistician interested in medical data. The books reflect the difference. To the clinician who wants to use statistics rather than validate them, Dr. Franzblau's book is better. It makes good reading and the examples are homely. Dr. Croxton's style is somewhat more turgid. And he uses 20 pages for an explanation of the chi square concept, which Dr. Franzblau handles in 4 pages. The Croxton opus is a bit heavy, and a typical page is gravid with mathematical formulae. The Franzblau text races and the Croxton text crawls. This is not to say that Dr. Croxton's book is a bad one. On the contrary it is an excellent and solid summary of statistical technics. It is also a remarkable bargain: a 376 page manual for only $1.95! Furthermore the Croxton book has a far more useful set of appendices including full logarithmic tables. Any doctor doing serious research, who is not a mathematician, ought to have at least the Franzblau book in his library. And if he wants to validate his own figures, he should study the Croxton text too.

ABRAHAM LEFF, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

NOVEMBER, 1959 ● VOL. XXXII, No. 9

THE "OPEN-NEGATIVE" PROBLEM

Clear cut definitions of "open-negative," "relapse" and "bacteriologic remission" are recommended by the Committee on Therapy of the American Trudeau Society as a means of dispelling the present confusion surrounding this problem.

The "open-negative" problem is largely a product of the chemotherapy era. Formerly the persistence of open cavity on the roentgenograms of a tuberculous patient was almost invariably associated with the ability to recover tubercle bacilli from his secretions. Today, however, the majority of patients receiving a first course of effective chemotherapy for cavitary tuberculosis pass through a phase of bacteriologic remission while one or more cavities are still open. In some, this is followed by cavity filling or closure leading to an inactive classification. In others, the bacteriologic remission and persistent open lesion coexist for months or even years. This group of cases constitutes the "open-negative" problem.

The problem is that, after eight years of experience, agreement on the treatment and prognosis of these patients is lacking. Much of the conflict appears to be the result of the different ways in which various reporters use the terms "open-negative" and "relapse."

For the purposes of this report an "open" lesion is a hole or space in an area of the lung previously involved by tuberculosis, containing air and usually surrounded by a wall of sufficient density to be recognizable as such morphologically or roentgenographically. Not included are: (1) areas of increased radiolucency of segmental or lobar extent without a definite wall; and (2) former cavities, from which all air is absent; and (3) bullae, cysts, and areas of cystic or saccular bronchial dilatation when these can be differentiated with reasonable certainty from residual tuberculous cavities—a distinction not always possible.

The duration of bacteriologic remission required for inclusion in the "open-negative" category must be arbitrary. It is recommended that tubercle bacilli shall have been absent from the sputum and gastric contents examined at monthly intervals for at least six months. It is also recommended that the term "open-negative" be supplemented by indicating the duration of bacteriologic remission: thus "open-negative 6 months" or "open-negative 18 months."

INCIDENCE AND DIAGNOSIS

It has been estimated that approximately 90 per cent of patients who receive a first course of effective chemotherapy for cavitary pulmonary tuberculosis will achieve bacteriologic remission (reversal of infectiousness, sputum conversion) during the first eight months of treatment. More than half of such patients, however, will still have roentgenographic evidence of cavity if examined carefully.

The diagnosis of an open lesion on chest roentgenograms or planigrams preoperatively is usually followed by its discovery in the resected specimen. In general, an open lesion of some kind will be found in the resected specimen in 75 to 85 per cent of cases when one is reasonably suspected after careful examination of serial roentgenograms. The more equivocal the roentgenogram, the poorer this correlation becomes.

A Statement of the Committee on Therapy, American Trudeau Society, *The American Review of Respiratory Diseases, Vol. 80, No. 1, July, 1959.*

Although much has been made of the advanced state of healing in some resected "open-negative" lesions, this is a relative thing which is usually compared with the morphologic appearance of cavities resected without drug coverage or obtained at autopsy. Even today with effective chemotherapy, the majority of resected "open-negative" lesions show residual caseous foci and granulation tissue irregularly distributed in and along the cleanly sloughed, fibrotic cavity wall.

It has been shown that the longer the period of bacteriologic remission prior to resection in surgically treated cases, the more advanced the healing process appears and the more difficult it is to recover viable bacilli. A similar correlation between the duration of bacteriologic remission and the morphology and tissue bacteriology in unresected "open-negative" cases is often assumed, but specific proof is missing.

RELAPSE

If one wishes to measure the prognostic significance of the "open-negative" state by the incidence of relapse, one must arbitrarily define relapse. Simultaneous roentgenographic worsening and positive bacteriologic findings are universally accepted as evidence of relapse. It is proposed that recovery of tubercle bacilli by sputum culture or smear or gastric culture in a patient classified as "open-negative" be considered a relapse. While it might seem desirable to require more than a single positive bacteriologic finding for relapse, the tendency to introduce new drugs or other measures after even a single positive culture, especially when unsuspected drug resistance is noted, is very common and a second positive bacteriologic finding might thereby be prevented or masked, thus lowering the relapse incidence artificially.

Unfavorable roentgenographic changes with smears and cultures repeatedly negative for tubercle bacilli may be due to nontuberculous pulmonary diseases. Such changes, therefore, should rarely, if at all, be counted in tabulating tuberculosis relapse incidence in the "open-negative" group. The physicians may elect quite properly to treat such a patient as a case of tuberculous relapse in the absence of bacteriologic confirmation, but for statistical purposes such cases should be classified separately. The same applies to patients who show signs of clinical worsening such as fever, weight loss, increased cough, expectoration, or even hemoptysis without roentgenographic change or bacteriologic confirmation of tuberculous etiology. The role of indefinite prolongation of drug therapy in preventing relapse needs investigation. The earlier a relapse occurs, the more likely it is to occur while drugs are still being given; the later the relapse occurs, the more likely it is to follow cessation of chemotherapy.

IN SUMMARY

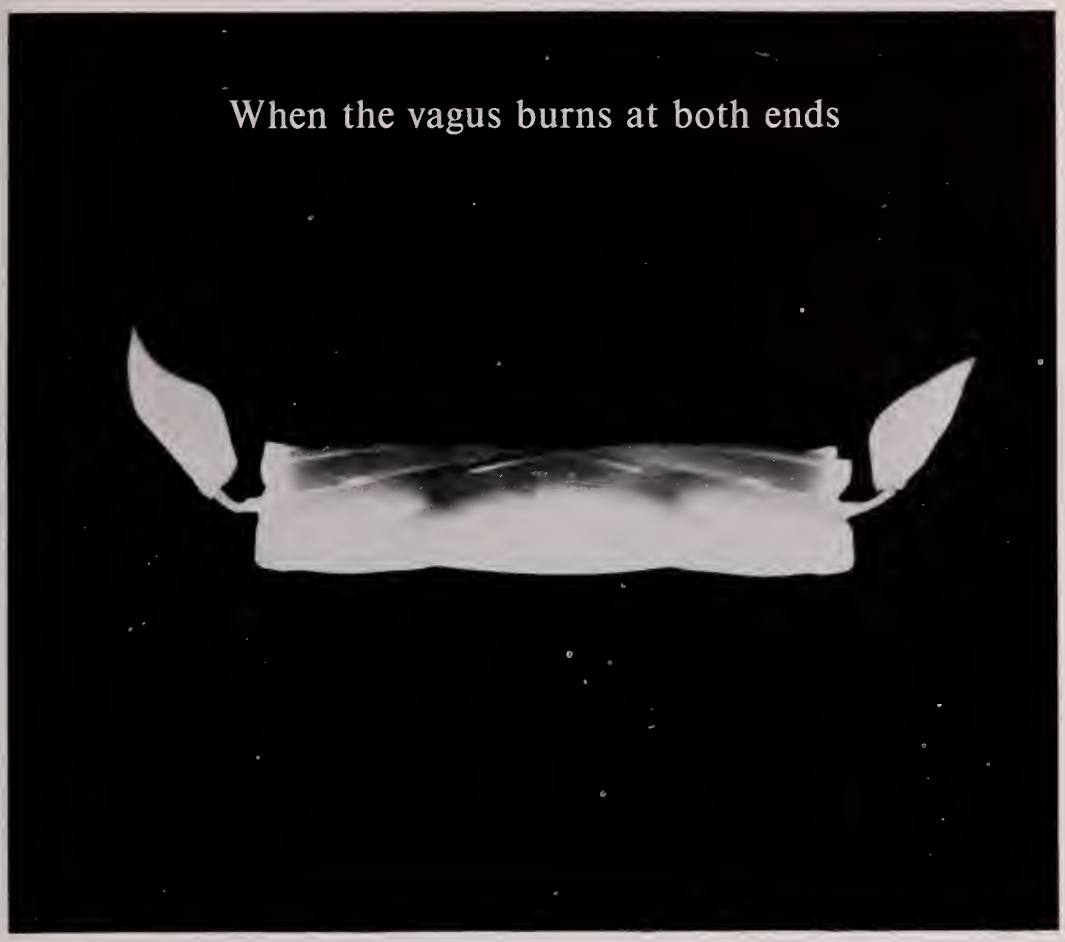
The problem of persistent open cavity with bacteriologic remission of greater or less duration is a phenomenon peculiar to the era of effective chemotherapy for tuberculosis. The roentgenographic findings fairly represent the morphologic findings in the majority of patients whose lesions are resected and may also reflect the findings in unresected lesions.

The definition of "open-negative" based on the presence of a cavity and inability to recover tubercle bacilli from secretions is arbitrary, but a bacteriologic remission of six months or longer is recommended for inclusion in this category. Relapse should be defined as bacteriologic escape or combined roentgenographic-bacteriologic worsening, but not as clinical or roentgenographic worsening without bacteriologic proof of its tuberculous etiology.

The relationship between relapse, duration of bacteriologic remission, and the duration of effective drug therapy is in need of further study. Only then can the relative risk of relapse and the risk of resection in patients exemplifying the "open-negative" problem be fairly weighed.

Thomas B. Barnett, Edward Dunner, H. Corwin Hinshaw, Gardner Middlebrook, Donald L. Paulson, James W. Raleigh, William W. Stead, James A. Wier, *chairman*.

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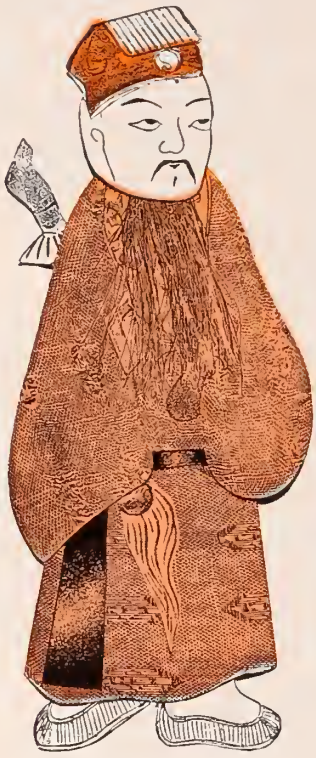
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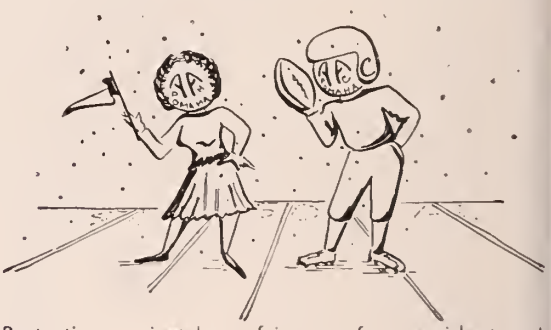
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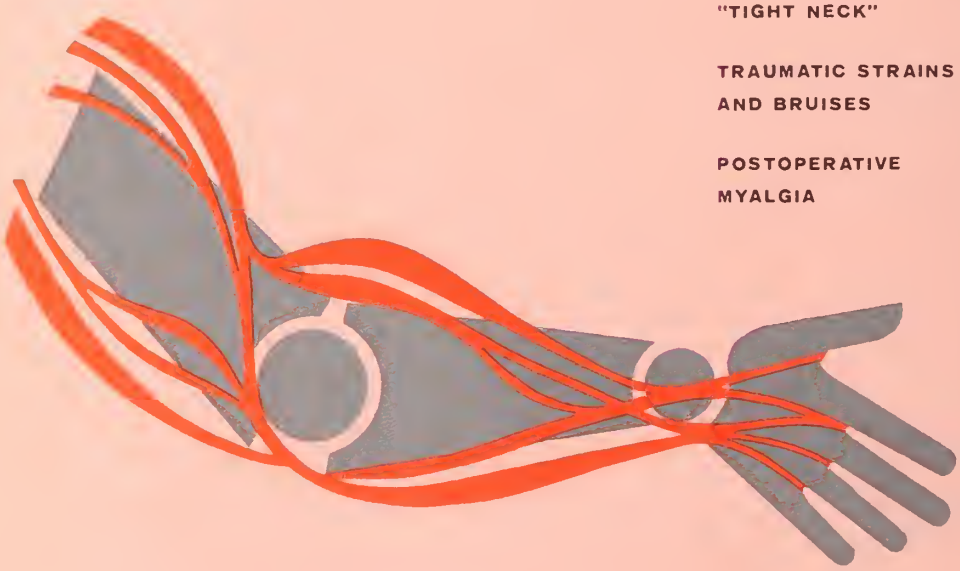
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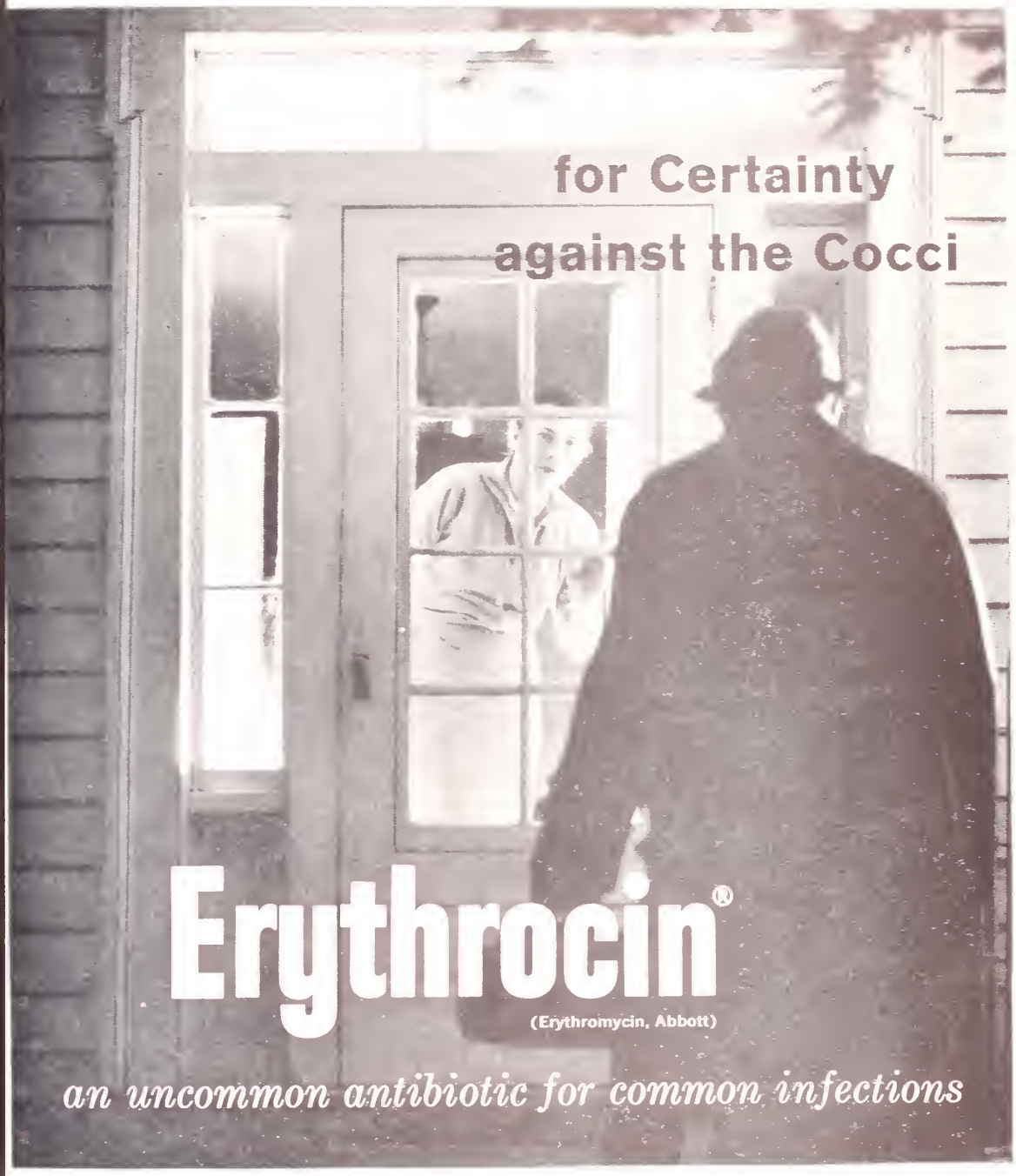


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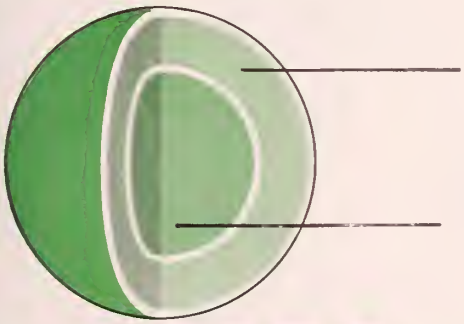
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Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.

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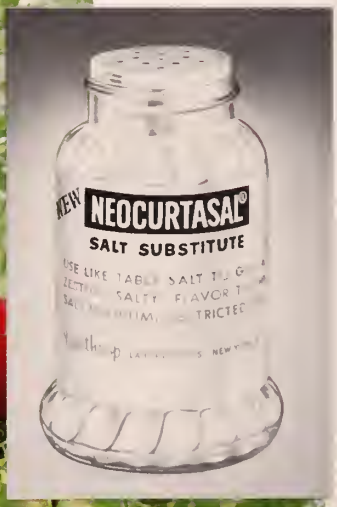
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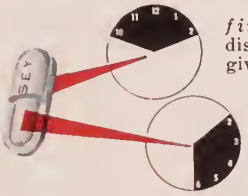
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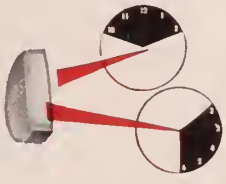
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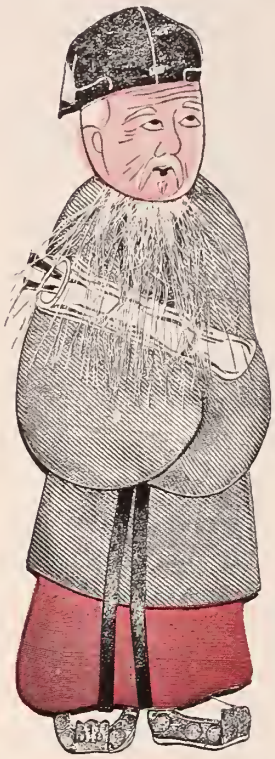
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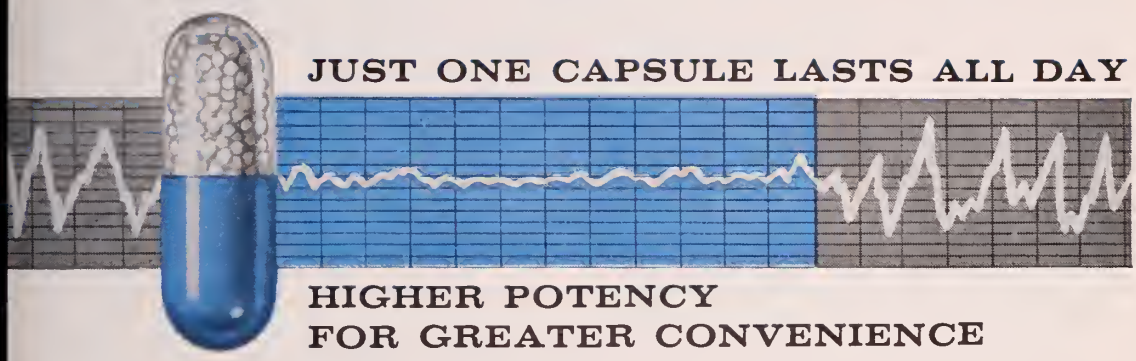
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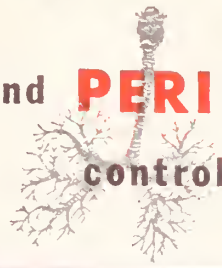
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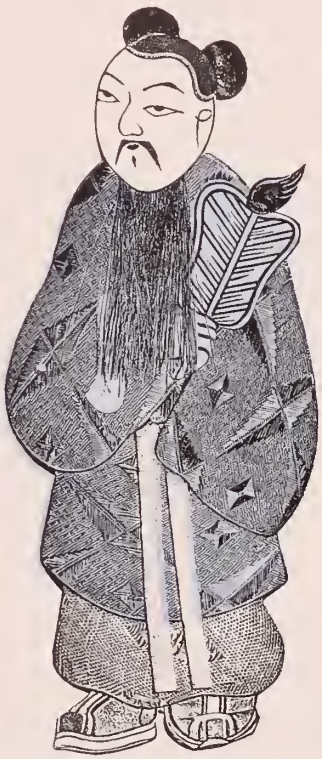
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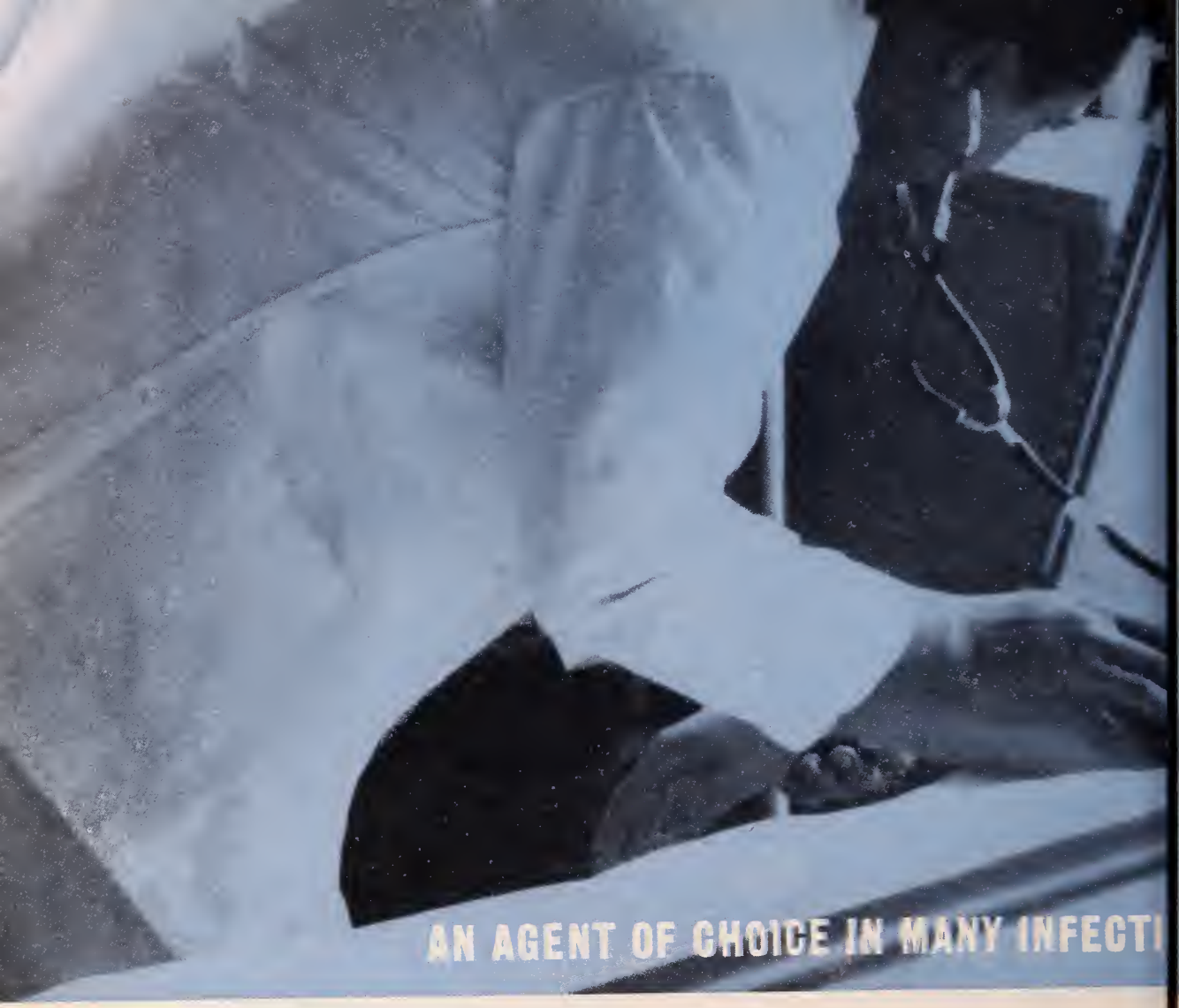
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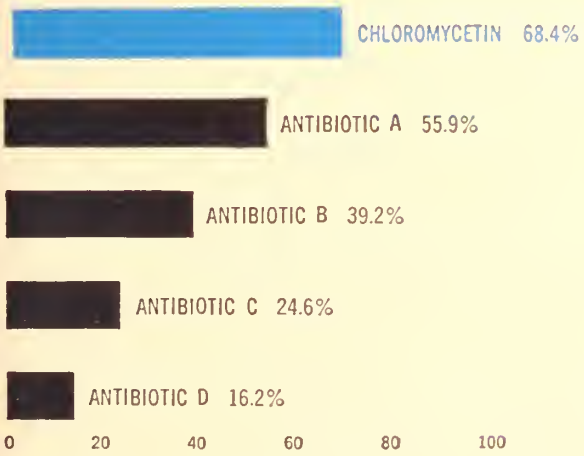
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REFERENCES: (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957. (2) Suter, L. S., & Ulrich, E. W.: *An*
Chemother. 9:38, 1959. (3) Murphy, J. J., & Rattner, W. H.: *J.A.M.A.* 166:616, 1958. (4) Rhoads, P. S.: *Postgrad. Med.* 21:
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THE JOURNAL

OF

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CONTENTS—Pages 711 to 768

N.Y. ACAD. OF MEDICINE DEC 22 1959 LIBRARY

EDITORIALS— Page

Hospitalizing the Alcoholic 711

The Reporting of Side Effects 712

The Doctrine of Causation 712

ORIGINAL ARTICLES—

Tendinitis and Peritendinitis—Daniel E. Kavanaugh, M.D., Newark, N. J. 713

Prevention of Prematurity and Fetal Anoxia—Robert E. L. Nesbitt, Jr., M.D., Albany, New York 719

Management of Alcoholism in a General Hospital—Allen A. Parry, M.D., Madison, N. J. 725

The Value of Twins to the Paternity Referee—Thomas K. Rathmell, M.D., Trenton, N. J. 730

Ephedrine and Antihistamine Treatment in Allergies—M. W. Flothow, Jr., M.D., *et al.*, Morristown, N. J. 733

ORIGINAL ARTICLES— Page

Diagnostic Approach to Diarrhea Problem—Samuel M. Gilbert, M.D., Newark, N. J. 735

Treatment of Dermatomycoses with Griseofulvin—Reuben Yontef, M.D., Bayonne, N. J. 738

Rupture of Stomach in the Newborn—Paul de R. Kolisch, M.D., Phillipsburg, N. J. 741

HISTORICAL ARTICLE—

"To Repeal All Medical Laws . . . "—Fred B. Rogers, M.D., Trenton, N. J. 745

OBITUARIES 747

ANNOUNCEMENTS 748

COUNTY SOCIETY REPORTS 750

BOOK REVIEWS 754

ANNUAL INDEX 1959 757

NTA ABSTRACTS 767

Roster of Officers and Committee Chairmen, Advertising Page 3A

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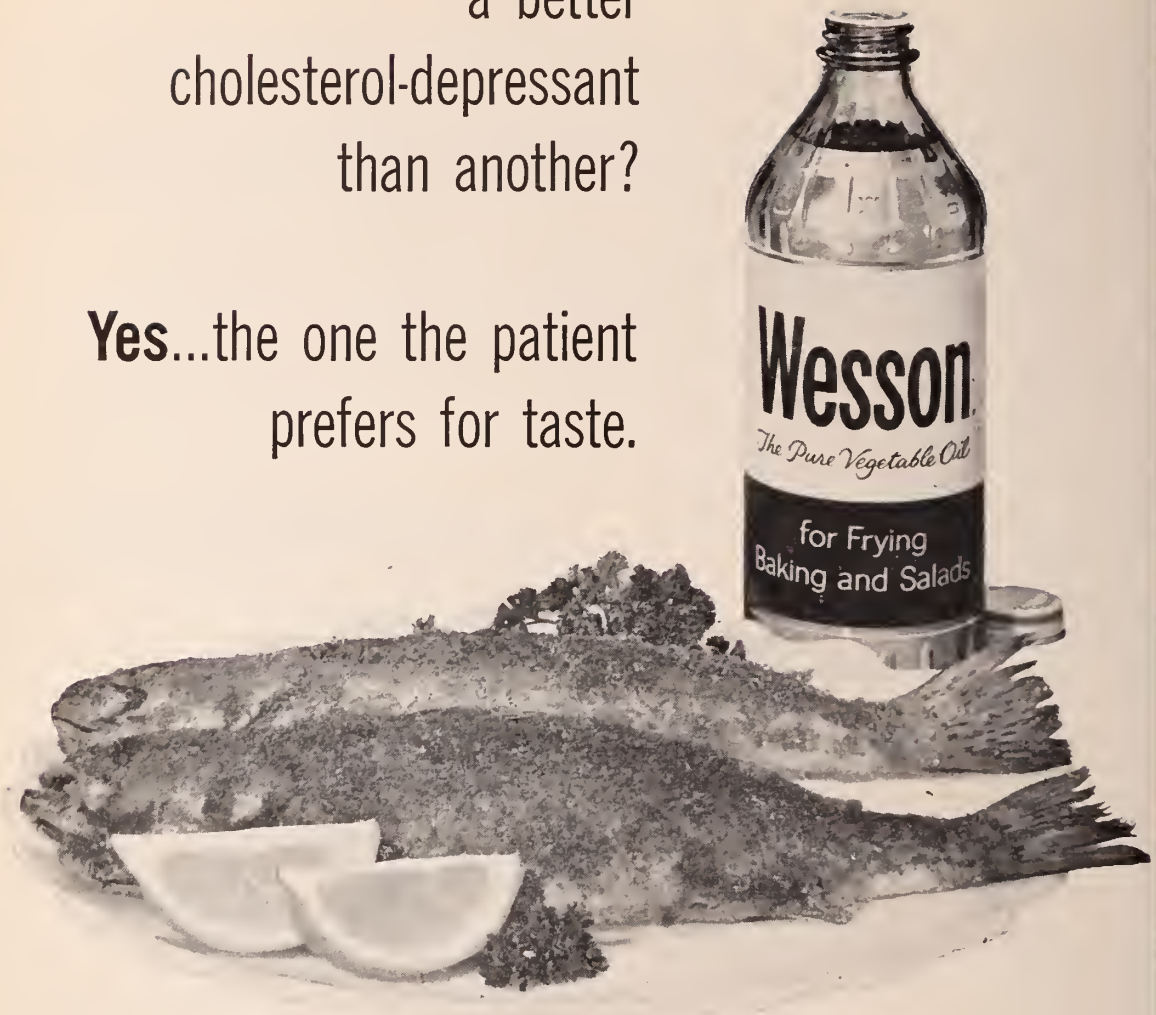
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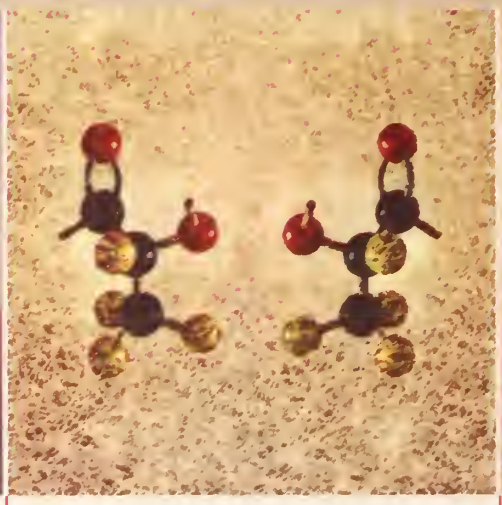


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ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN

BRISTOL

ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

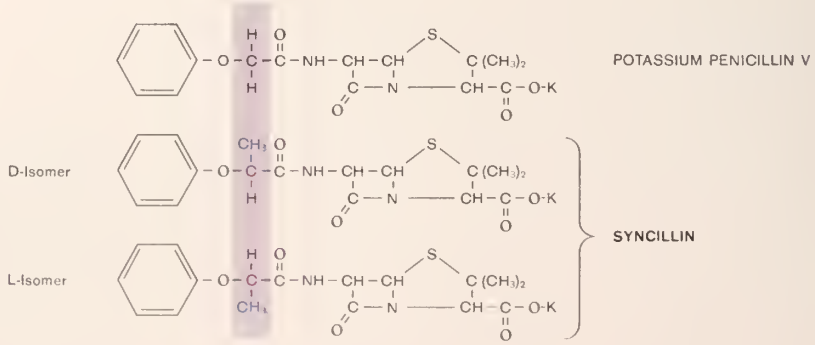
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and α-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.[1]

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH_3 group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH_3 group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.





SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

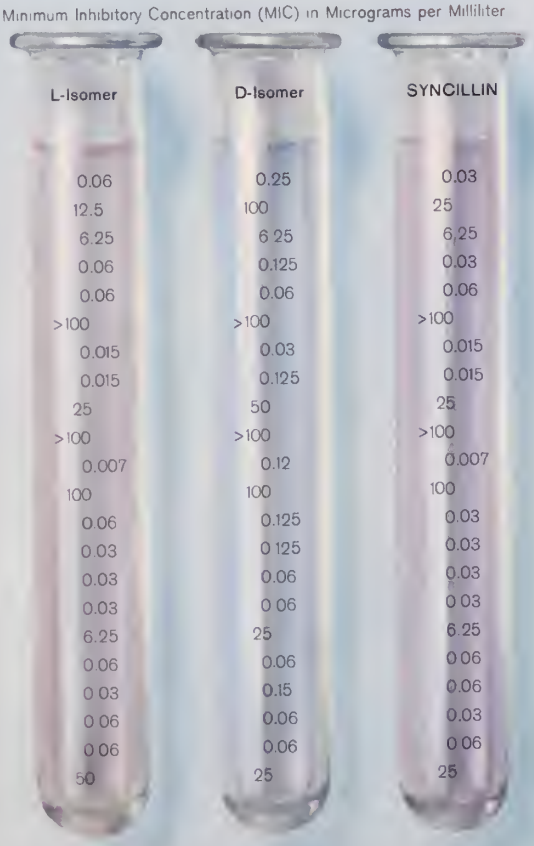
ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against Salmonella, *E. coli,* and other gram-negative coliform bacilli.

SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1

Minimum Concentrations of SYNCILLIN and Components Required to Inhibit a Wide Range of Bacteria



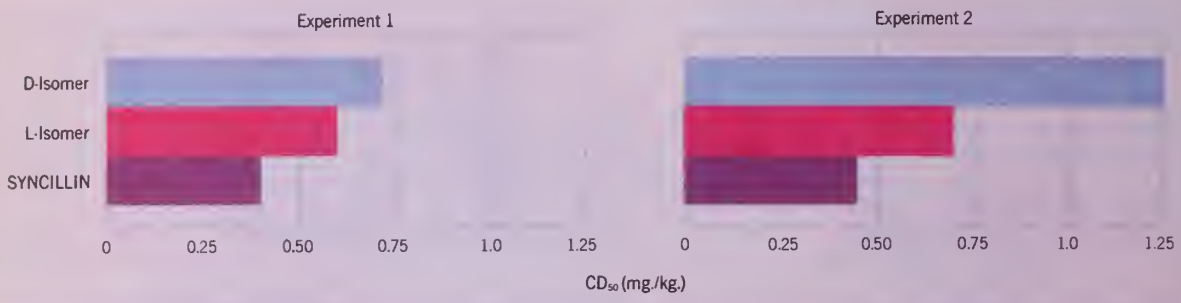
	L-Isomer	D-Isomer	SYNCILLIN
Bacillus anthracis	0.06	0.25	0.03
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6 25	6,25
Corynebacterium xerosis	0.06	0.125	0.03
*Diplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0.015	0.125	0.015
Salmonella paratyphi A	25	50	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0.007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.125	0.03
Staphylococcus aureus var. Smith	0.03	0 125	0.03
Streptococcus agalactiae ATCC 1077	0.03	0.06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0 06	0 03
Streptococcus faecalis PCI 1305	6.25	25	6.25
*Streptococcus pyogenes 203	0.06	0.06	0 06
*Streptococcus pyogenes Digonnet	0 03	0.15	0.06
Streptococcus pyogenes 2320	0 06	0.06	0.03
Streptococcus pyogenes 23586	0 06	0.06	0 06
Vibrio comma	50	25	25

Serial dilution technique in heart infusion broth *10% serum added

ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose (CD_{50}) for *Staphylococcus aureus* (var. Smith) Infections

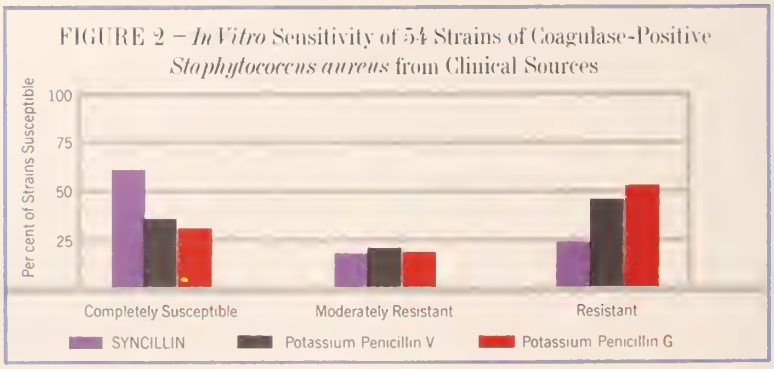


MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright[2] performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

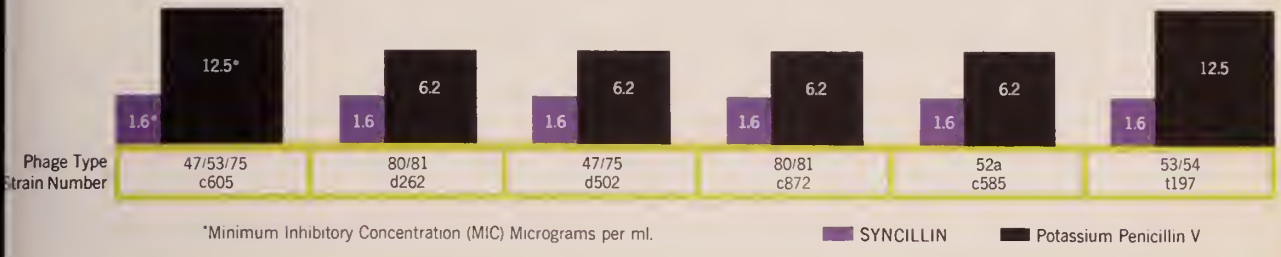
FIGURE 2 – *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources



Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

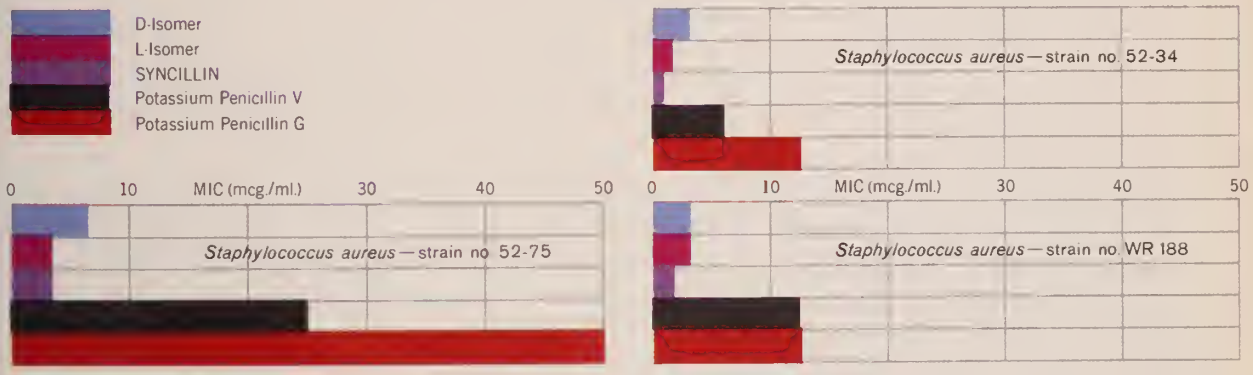


The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figure 1)*

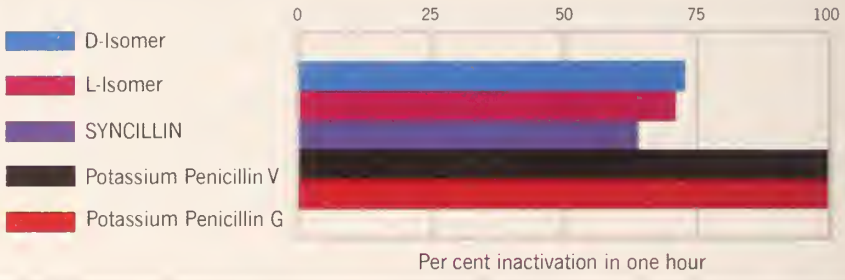
—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.[4] As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.

FIGURE 5—Effect of Staphylococcal Penicillinase on Different Penicillins

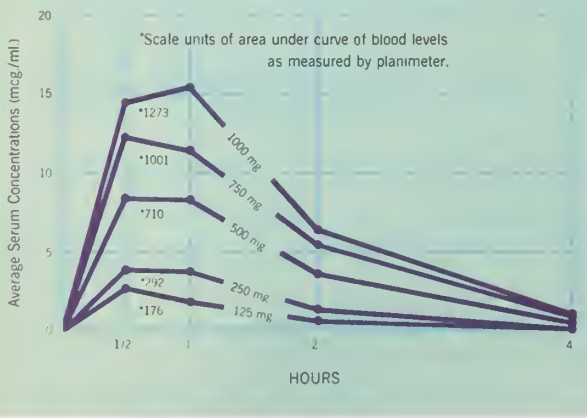


ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

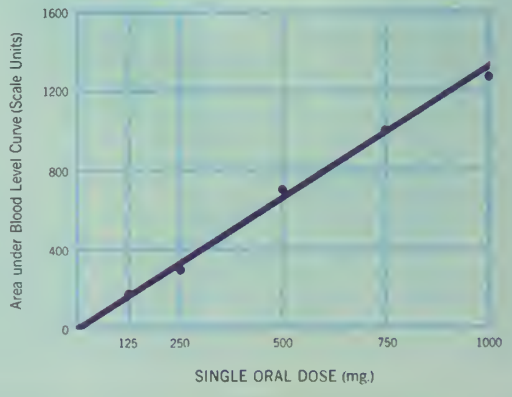
Cronk[5] studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.

FIGURE 6

Serum Levels With Varying Dosage



Antibiotic Activity With Varying Dosage



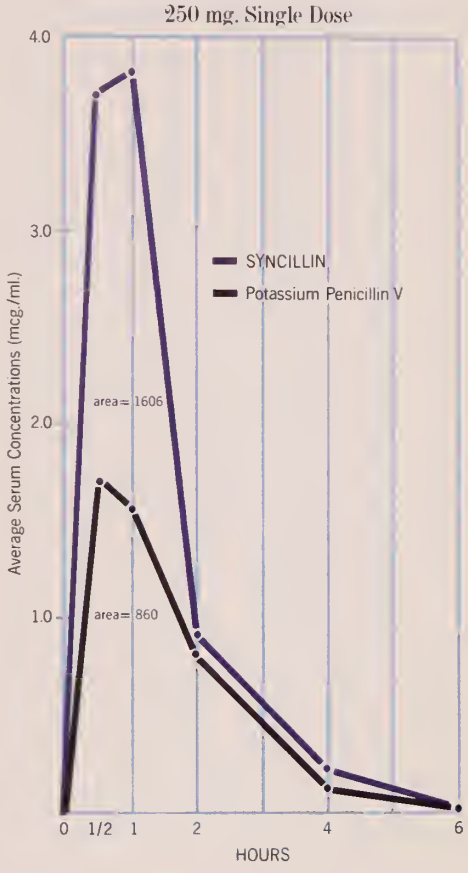
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright[6] performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.[7] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

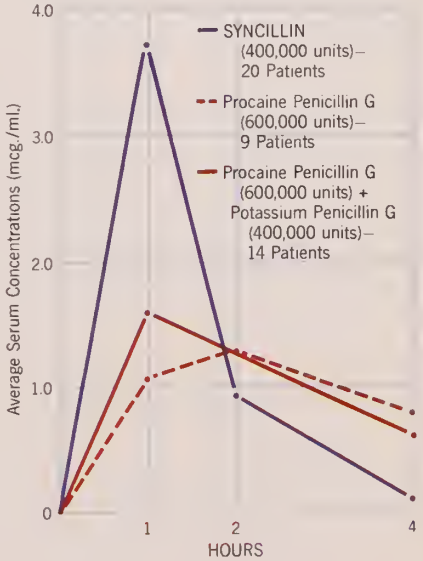
FIGURE 7
20 Subject Crossover
250 mg. Single Dose



BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN[6] are much higher than those with intramuscular penicillin G.[8a, b] (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal*, these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

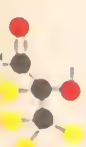
As Flippin[9] recently stated, "... it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted. . . . In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.[10]

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,[11] White,[12] Prigot,[13] Robinson,[14] Dube,[15] Ferguson,[16] Rutenburg,[17] Richardson,[18] Bunn,[19] Cronk,[5] Kligman,[10] and Yow [20] demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

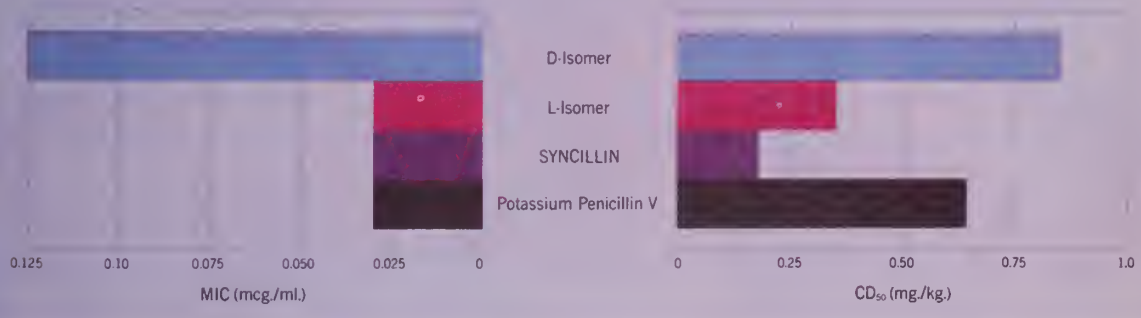
Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers* (SYNCILLIN) *is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN *(one-third that of penicillin V)* was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

FIGURE 9 — Comparison of CD_{50} and MIC Values Against *Staphylococcus aureus* (var. Smith)



Isomeric complementarity has thus been demonstrated for:

— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

— *penicillin-susceptible staphylococci* in vivo *(Figures 1 and 9)*

— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

— *staphylococcal penicillinase antibiotic inactivation (Figure 5)*

Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. *18*:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. *62*:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.: Clinical report to Bristol Laboratories Inc.

BRISTOL

major therapeutic advantages accompany molecular asymmetry

SYNCILLIN

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

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NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

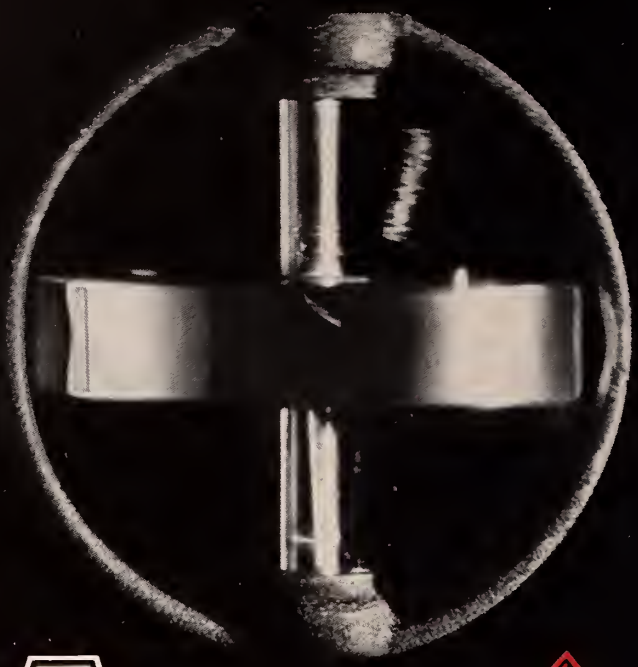
† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

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minimal disturbance
of the patient's chemical and psychic balance . . .



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Substantiated by published reports of leading clinicians:

- **effective control** of allergic and inflammatory symptoms[1-20]
- **minimal disturbance** of the patient's chemical and psychic balance[1, 4, 5, 8-19]



i-inflammatory and antiallergic levels ARISTOCORT means:

freedom from salt and water retention

virtual freedom from potassium depletion

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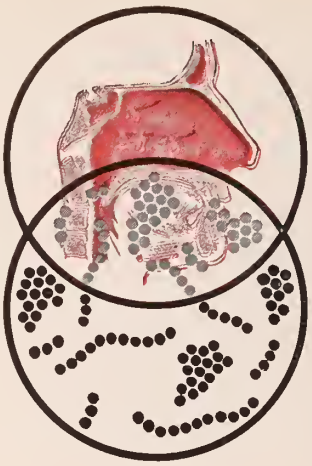
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no voracious appetite—no excessive weight gain

low incidence of peptic ulcer

low incidence of osteoporosis with compression fracture

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when upper respiratory congestion is complicated by bacterial invaders

TRISULFAMINIC provides logical therapy

- for the patient ill with congestion and infection of the upper respiratory tract, as in purulent rhinitis, sinusitis, tonsillitis and otitis media, when caused by sulfa-susceptible bacteria;
- because secondary invasion by such bacteria so frequently follows the common cold.[1]

the reasons for combining Triaminic with triple sulfas

Triaminic and triple sulfas are not only pharmacologically *compatible*, they are a therapeutically *logical* combination for upper respiratory infections: Triaminic for effective decongestant relief from rhinitis, rhinorrhea and sinusitis;[2] triple sulfas for well-established antibacterial action.

The advantages of Trisulfaminic in upper respiratory infections include: proved effectiveness; safety; economy; ease of administration; less likelihood of sensitivity reactions;[3] compatibility with antibiotics and other antibacterial therapy. Provided also as Suspension for additional convenience.

Trisulfaminic®

TRIAMINIC WITH TRIPLE SULFAS

Available as TABLETS and SUSPENSION

Each easy-to-swallow Trisulfaminic Tablet or 5 ml. teaspoonful of Suspension provides:

Triaminic® .....25 mg.
(phenylpropanolamine HCl 12.5 mg.
pheniramine maleate ..... 6.25 mg.
pyrilamine maleate ..... 6.25 mg.)
Trisulfapyrimidines, U.S.P. .....0.5 Gm.

Dosage:

Adults—2 to 4 tablets or tsp. initially, followed by 2 tablets or tsp. every 4 to 6 hours until the patient has been afebrile 3 days. *Children 8 to 12* — 2 tablets or tsp. initially, followed by 1 tablet or tsp. every 6 hours. *Children under 8*—dosage according to weight.

The palatability, convenience and effectiveness of the Suspension make it especially suitable for children and for those older patients who prefer liquid medication.

References: 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

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VISTARIL has an outstanding record of safety and is valuable adjunctive therapy in home or hospital when administered to patients with peptic ulcer, gastroenteritis, esophageal spasm, and nervous dyspepsia.

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Sulfadiazine	0.162 Gm.
Sulfamerazine	0.162 Gm.
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Sodium Citrate*	0.375 Gm.

*not contained in Tri-Sulfanyl Tablets.



Tri-Sulfanyl Syrup: 4 oz., 16 oz., and gallon
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... to unexcelled sulfa control of KYNEX. Lower dosage of just ½ Gm. daily ... prolonged action without hazard of crystalluria ... reduced toxic potential ... not surpassed by any other sulfa drug, singly or in combination. Dosage: Two tablets q.i.d. first day; one tablet q.i.d. thereafter. Each tablet contains: 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.

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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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- Swiftly relieves itching, burning, malodor and leukorrhea
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- Achieves clinical and cultural cures where others fail
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Rx new box of 24 suppositories with applicator for more practical and economical therapy.

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Fluphenazine dihydrochloride

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safely controls the "target symptoms" of
emotional stress with the smallest effective dosage
of any neuroleptic* agent (0.25 mg. b.i.d.)

virtually free from side effects at the
recommended dosage level

a significantly wider spectrum of "target symptoms"
is amenable to therapy

onset of action is rapid; duration of effect is prolonged

**Neuroleptic*—"The term 'neuroleptic' implies a specific effect of a pharmacologic agent on the nervous system. It refers to a mode of action on affective tension that distinguishes this response from that to hypnotic drugs. The terms 'ataraxics' and 'tranquilizers' are descriptively impressive, but fail to convey what seems psychopharmacologically unique."[1]

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"Fluphenazine (PERMITIL) the latest and most potent phenothiazine tranquilizer was administered from 3 to 20 months to 200 ambulatory and hospitalized patients representing a full spectrum of diagnostic classifications including psychosomatic disorders. Fractional doses of this drug rapidly produced improvement in 74% of these patients while causing a minimum of sedative, autonomic and endocrine effects which disappeared as treatment continued. . . . Patient acceptance of this compound was excellent because its prescription facilitated rather than interfered with the efficient performance of daily tasks. The physician who masters the art of fluphenazine use can treat a widened spectrum of target symptoms, safely and effectively."[2]



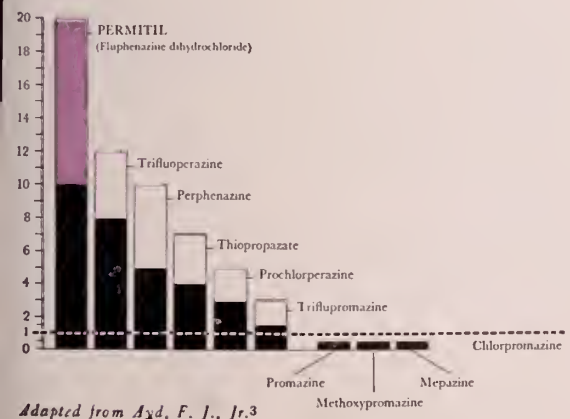
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anti-anxiety agent
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A Factor to Consider in Phenothiazine Therapy

"The more potent the phenothiazine derivative the fewer the side effects it produces, because less of the chemical is needed to effect behavioral and therapeutic changes."[2]

The structure of PERMITIL has made it, on a mg. for mg. basis, "at least twice as potent as trifluoperazine, 3-5 times as potent as perphenazine and 10-20 times as potent as chlorpromazine, while increasing its speed and duration of action with a minimum of sedative, autonomic and endocrine side effects."[2]

The Relative Therapeutic Potency
of Various Phenothiazines



Adapted from Ayd, F. J., Jr.[3]

Clinical Results with PERMITIL—a Phenothiazine

In one study[2] covering a two-year period, PERMITIL was prescribed for 200 patients who were disabled primarily by anxiety and its somatic, emotional, mental and behavioral effects.

"After 3 months of fluphenazine (PERMITIL) therapy, 74% or 148 of the 200 patients evaluated were improved. Of the 102 patients with a poor pretreatment prognosis, 69 improved, while 79 of the 98 patients with a good prognosis improved. Thus the therapeutic effectiveness of fluphenazine (PERMITIL) is somewhat better than that of other potent tranquilizers."[2]

The relatively minor somatic reactions occurred in the early weeks of treatment with doses above 2 mg. daily. They seldom required other medication to counteract them and disappeared as the maintenance dose was established. At dosage levels under 3 mg. a day, extrapyramidal side effects were minimal.

Prior to this study, 130 patients had urinalyses, hematologic studies (white blood count and differential), and liver function tests (cephalin flocculation, bilirubin direct and indirect, and alkaline phosphatase). These tests were repeated between 3 and 6 months in 50 patients, between 6 and 12 months in 50 patients and between 12 and 18 months in 30 patients. The minimum total dosage was 139 mg. Results of these tests disclosed that "fluphenazine (PERMITIL) administered over 3 to 18 months had no deleterious effect on the blood, liver or kidney in these patients."[2]

The Importance of PERMITIL in Everyday Practice

"In contrast to other phenothiazines, it (PERMITIL) mitigates apathy, indifference, inertia and anxiety-induced fatigue. Thus, instead of impeding effective performance of daily tasks, it increases efficiency by facilitating psychic relaxation. Consequently, acceptance of this drug, especially by office patients, has been excellent."[2]

How to Prescribe PERMITIL For most adults: One 0.25 mg. tablet b.i.d. (taken morning and afternoon). In refractory cases: Two 0.25 mg. tablets b.i.d. Total daily dosage in refractory cases should not exceed 2 mg., in divided doses. Dosage for children has not been established. *Complete information concerning the use of this drug is available on request.*

Available as Tablets, 0.25 mg., bottles of 50 and 500.

References: 1. Freyhan, F. A.: Psychopharmacology Frontiers, Boston, Little, Brown and Co., 1959, p. 7. 2. Ayd, F. J., Jr.: Fluphenazine: its spectrum of therapeutic application and clinical results in psychiatric patients, Current Therapeutic Research, 1:41 (Oct. 15) 1959. 3. Ayd, F. J., Jr.: The current status of major tranquilizers, in press.

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Veratrite now contains cryptenamine which acts centrally to produce a gradual fall in blood pressure, yet improves circulation to vital organs, relieves dizziness and headache, and imparts a distinct sense of well-being. Furthermore, Veratrite achieves its effects with unusual safety and without annoying side effects.

Each Veratrite tabule contains: Cryptenamine (tannates), 40 C.S.R.* Units; Sodium nitrite, 1 gr.; Phenobarbital, ¼ gr. Dosage: 1–2 tabules t.i.d., preferably 2 hours after meals.

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d-amphetamine
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Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

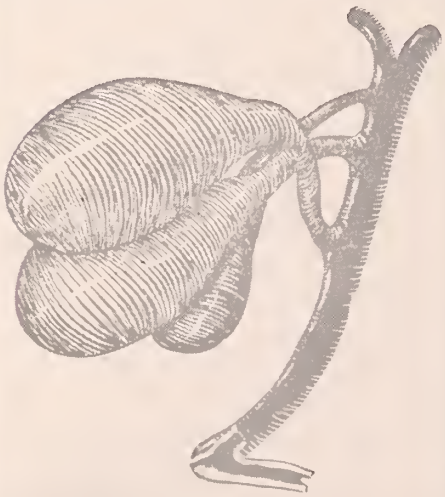
AN AMES CLINIQUICK™

CLINICAL BRIEFS FOR MODERN PRACTICE

HOW PREVALENT ARE MULTIPLE GALLBLADDER ANOMALIES?

One hundred and twenty-two cases of *vesica fellea divisa* (bilobed gallbladder) and *vesica fellea duplex* (double gallbladder with 2 cystic ducts) are reported in the literature. A unique case of *vesica fellea triplex* has recently been described.

Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



in medical management and postoperative care of biliary disorders...

"effective" hydrocholeresis...

DECHOLIN®

(dehydrocholic acid, AMES)

"...dehydrocholic acid...does considerably increase the volume output of a bile of relatively high water content and low viscosity. This drug is therefore a good 'flusher,' and is effectively used in treating both the chronic unoperated patient and the patient who has a T-tube drainage of an infected common bile duct."[1]

free-flowing bile
plus reliable spasmolysis

DECHOLIN® WITH BELLADONNA

"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."[2]

(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

AMES COMPANY, INC
Elkhart • Indiana
Toronto • Canada

64659

Synonyms for Pain Relief...

TABLOID' EMPIRIN' COMPOUND®

Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½

TABLOID' EMPIRIN' COMPOUND® WITH CODEINE PHOSPHATE*

No. 1
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . . gr. ⅛

No. 2
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . gr. ¼

No. 3
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . gr. ½

No. 4
Acetophenetidin . . . . . gr. 2½
Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . . gr. 1

*Subject to Federal Narcotic Regulations

...providing the desired gradation of potencies for relief of varying intensities of pain

IN

simple headache
rheumatic conditions
arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
minor trauma
tension headache
premenstrual tension
minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis bursitis

relief of pain of all degrees of severity up to that which requires morphine

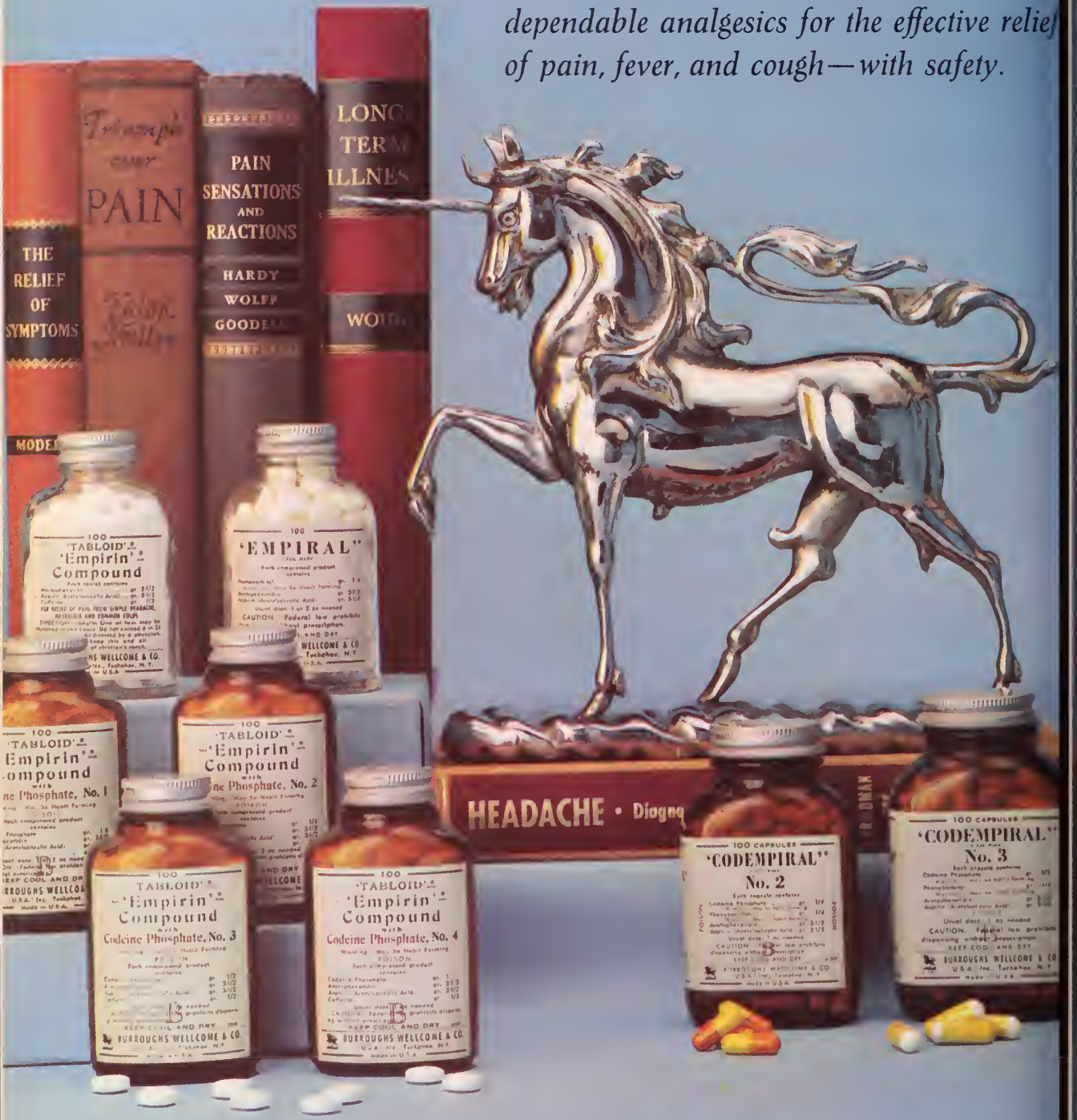
AND IN

fevers
dry, unproductive coughs



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Your experience and trust throughout the years have established the wide use of the 'Empirin' family in medical practice—dependable analgesics for the effective relief of pain, fever, and cough—with safety.



BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, New York

Counteract Depression with distinctively WELL-TOLERATED

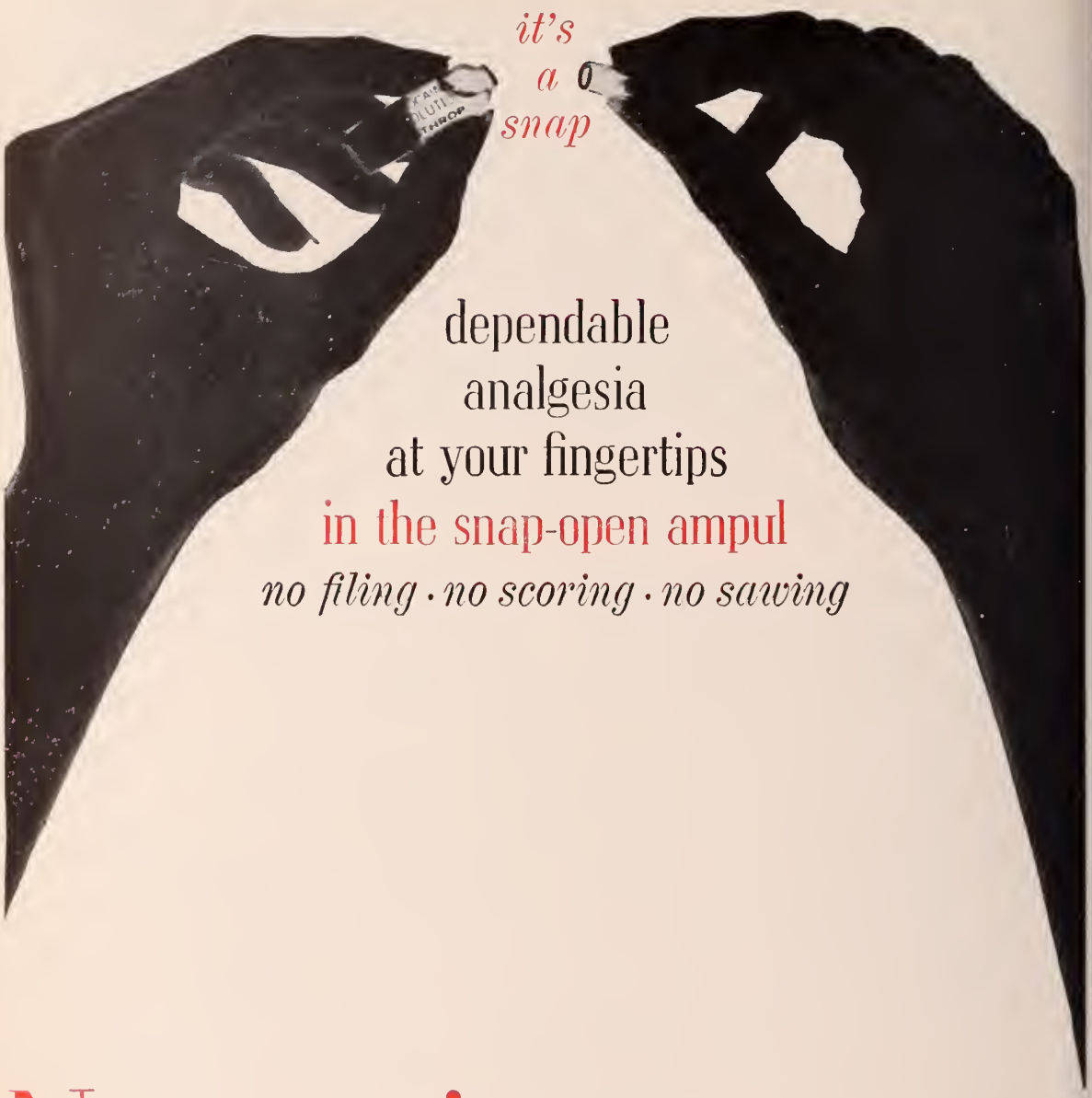
Deaner®

deanol acetamidobenzoate

- 'Deaner' may be prescribed with little or no concern over side effects even in the presence of liver disease, diabetes, cardiovascular disease, and a long list of other chronic conditions, except grand mal epilepsy (only contraindication).
- 'Deaner' *is not a monoamine oxidase inhibitor;* hence it is not necessary to monitor its administration with repeated, expensive laboratory tests.
- This notable freedom from side effects endows Deaner's long-term administration with easier patient supervision, better patient cooperation, and greater safety.
- Dosage is simple—initially, 50 mg. (2 tablets) daily in the morning. *Gradually, apathy and defeat are transformed into affability and renewed interest and vigor.*

Write for details and the applicability of 'Deaner' in behavior problems of children

Riker Northridge, California



it's a snap

dependable
analgesia
at your fingertips
in the snap-open ampul

no filing · no scoring · no sawing

Novocain®

PIONEER BRAND OF PROCAINE HYDROCHLORIDE

the local anesthetic with universal acceptance

Novocain 1%, 2%, 10%, 20% Solutions with or without vasoconstrictors.
Also available: Multiple Dose Vials with dual purpose caps for withdrawal by needle or pouring.

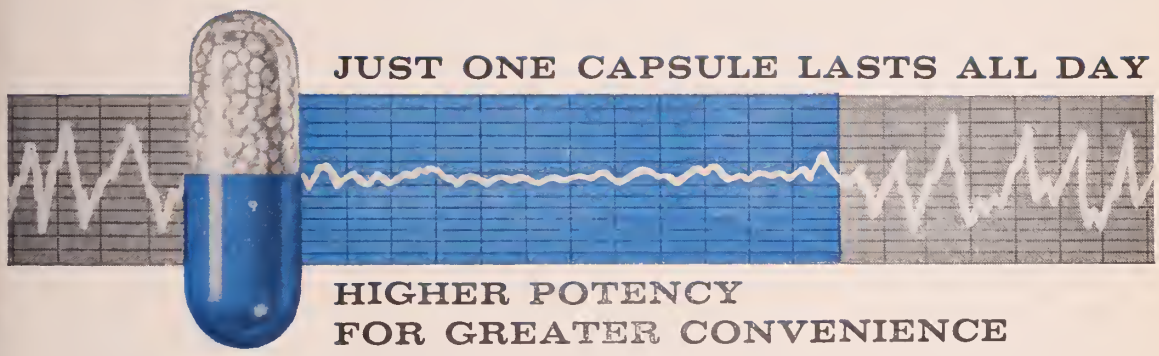
Winthrop LABORATORIES, NEW YORK 18, N.Y.

NEW AND EXCLUSIVE

FOR SUSTAINED TRANQUILIZATION

MILTOWN®(*meprobamate*) now available
in 400 mg. continuous release capsules as

Meprospan®-400



JUST ONE CAPSULE LASTS ALL DAY

**HIGHER POTENCY
FOR GREATER CONVENIENCE**

- relieves *both* mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

Usual dosage: One capsule at breakfast, one capsule with evening meal

Available: *Meprospan-400*, each blue capsule contains 400 mg. Miltown (meprobamate)
Meprospan-200, each yellow capsule contains 200 mg. Miltown (meprobamate)

Both potencies in bottles of 30.

®WALLACE LABORATORIES, *New Brunswick, N. J.*

CME-8426

whenever there is inflammation, swelling, pain

VARIDASE®

STREPTOKINASE-STREPTODORNASE LEDERLE

BUCCAL

Tablets

conditions for a fast comeback



as in episiotomy

VARIDASE Buccal provides a simple, natural way to faster, early healing. By activating the fibrinolytic enzymes responsible for normal recovery, VARIDASE shortens the catabolic phase of host response and reverses inflammatory reaction. Edema is reduced.

VARIDASE is not an anti-infective, but by increasing the permeability of the fibrin wall, it eases penetration of natural regenerative factors and fosters healthy tissue growth, making infection less likely.

VARIDASE Buccal Tablets contain:
10,000 Units Streptokinase and
2,500 Units Streptodornase.

Supplied: Boxes of 24 and 100.

Lederle

LEDERLE LABORATORIES,
a Division of American Cyanamid Co.,
Pearl River, New York

NIAMID*

brightens life for the aged

NIAMID gives the depressed elderly person a new sense of well-being. The family will notice a sunnier outlook, an alert interest in group activities, a renewed awareness of personal appearance, and a return of appetite. Your patient will be more cooperative and less demanding.

You can expect to see the same excellent response to NIAMID in a wide variety of depressive syndromes—acute or chronic, mild or severe, whether associated with long-standing or incurable illness, or masquerading as organic disease.

NIAMID side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. NIAMID has not been reported to cause jaundice, and significant hypotensive effects have rarely been noted.

DOSAGE: Start with 75 mg. daily in single or divided doses, and adjust according to patient response. NIAMID acts slowly, without rapid jarring of physical or mental processes. Some patients respond to NIAMID within a few days, but for full therapeutic benefit, most require at least two weeks. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already clinically proved in several thousand patients—

Complete references and a Professional Information Booklet giving detailed information on NIAMID *are available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

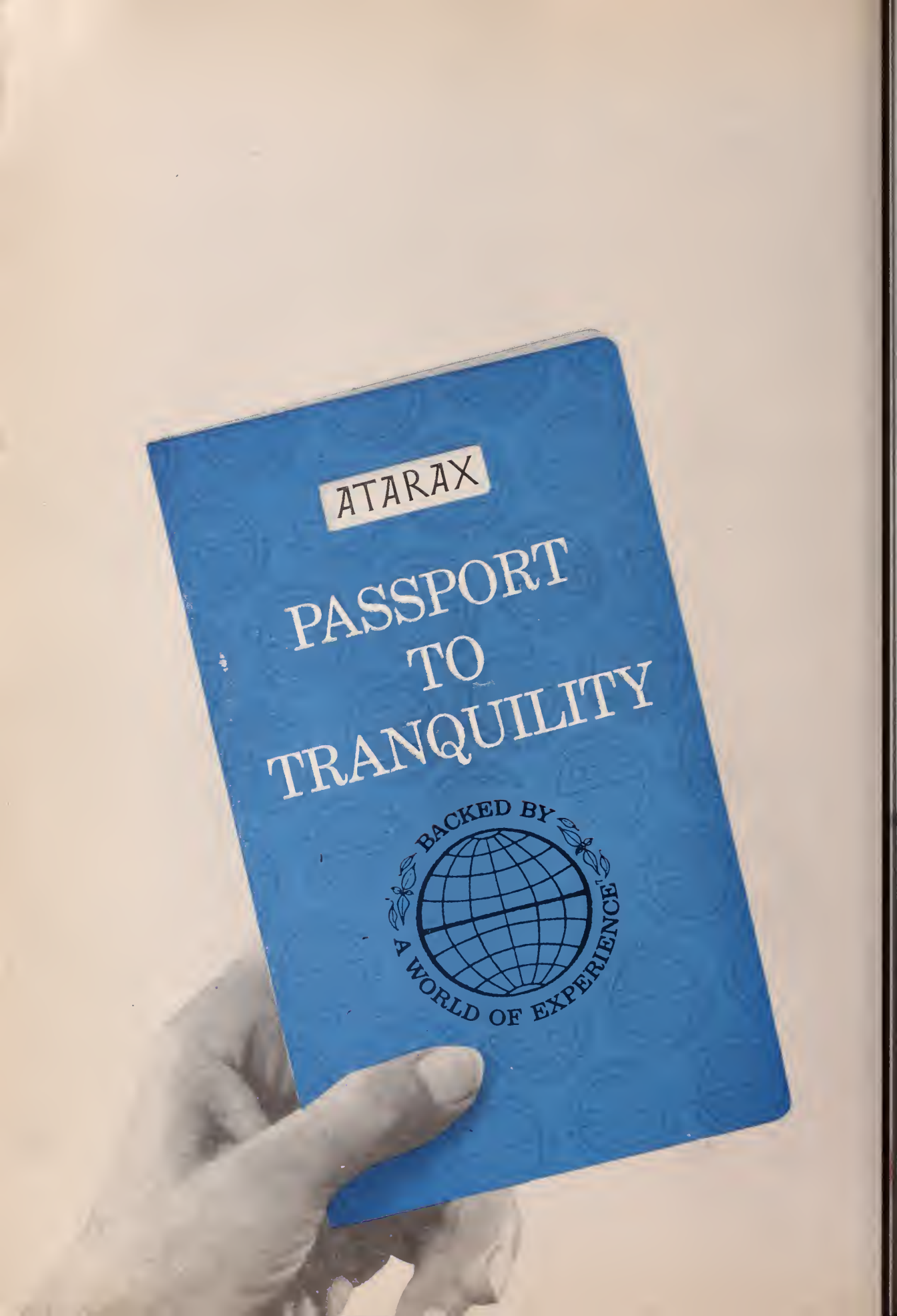
NIAMID

the mood brightener in geriatrics

*Trademark for nialamide

Pfizer Science for the world's well-being™




ATARAX
PASSPORT
TO
TRANQUILITY
BACKED BY
A WORLD OF EXPERIENCE

Passport

☞ a universal record of effectiveness

In anxiety, tension and agitation, ATARAX "... produced a more favorable state of calm and tranquility than any drug previously used."[1]

☞ widest latitude of safety and flexibility

No serious adverse reaction ever documented – five dosage forms and sizes

☞ chemically distinct among tranquilizers

Not a phenothiazine or a meprobamate

☞ added frontiers of usefulness

These unique benefits in specific indications

ANTIHISTAMINIC
ANTIARRHYTHMIC
ANTISECRETORY

BACKED BY A WORLD OF EXPERIENCE

Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN – 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

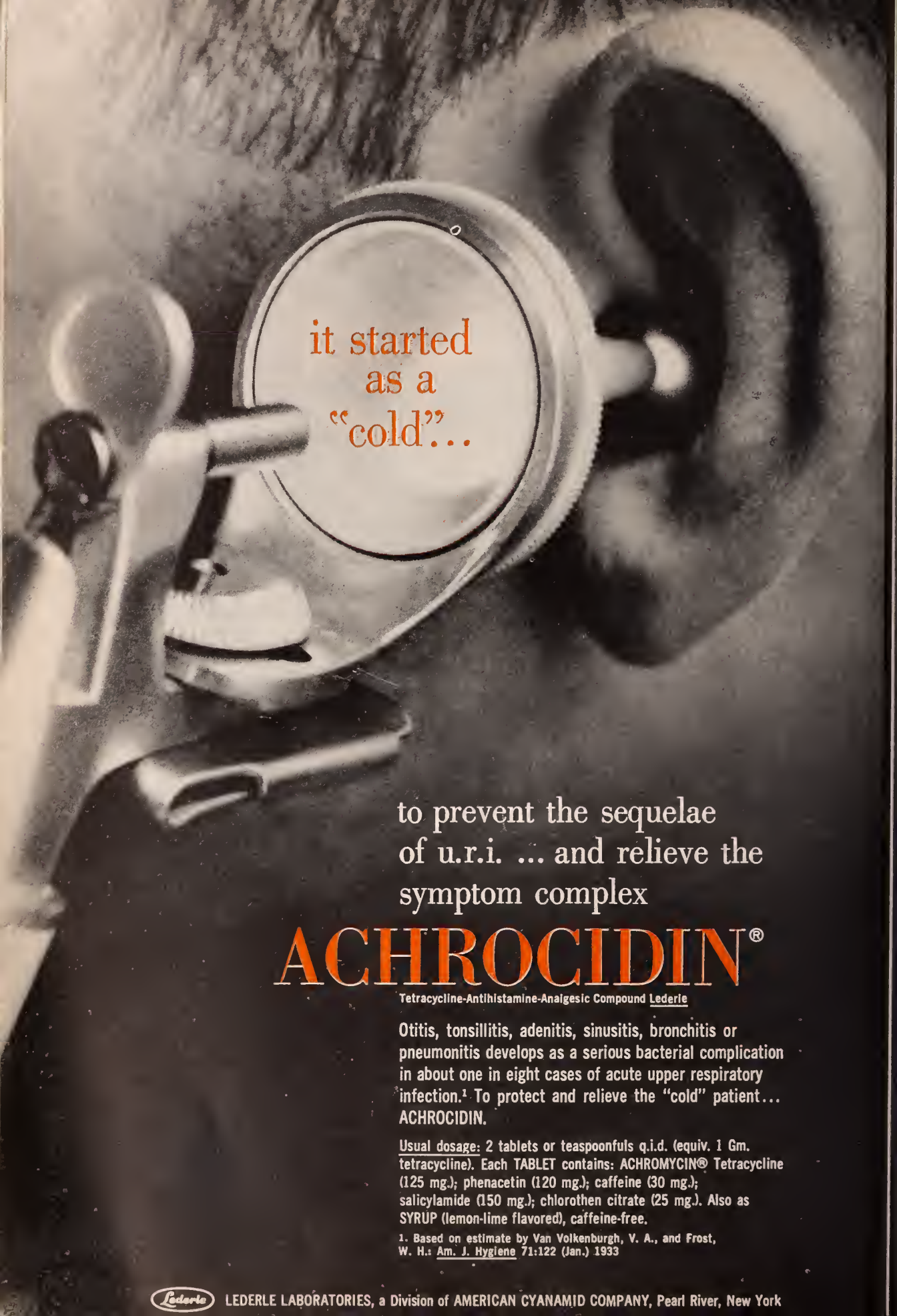
ATARAX®

d of hydroxyzine)

PASSPORT TO TRANQUILITY

Rx PFRIG

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being



to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Otitis, tonsillitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*–400 mg. *unmarked*, coated tablets.

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

CM-9470

NOW

. . . a new way to relieve pain and stiffness in muscles and joints

indicated in:

MUSCLE STIFFNESS

LUMBOSACRAL STRAIN

SACROILIAC STRAIN

WHIPLASH INJURY

BURSITIS

SPRAINS

TENOSYNOVITIS

FIBROSITIS

FIBROMYOSITIS

LOW BACK PAIN

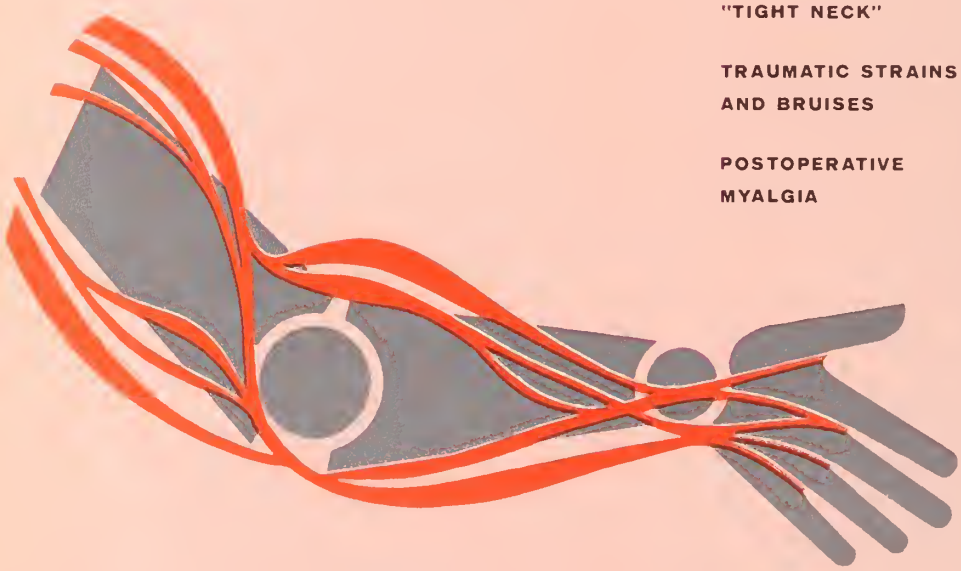
DISC SYNDROME

SPRAINED BACK

"TIGHT NECK"

TRAUMATIC STRAINS AND BRUISES

POSTOPERATIVE MYALGIA



■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

■ More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.
Literature and samples on request.

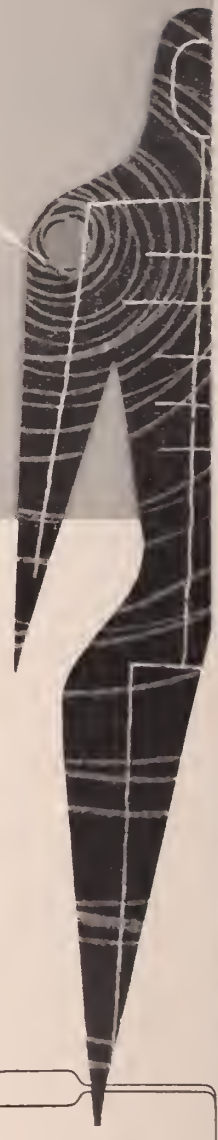
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NEW

DEPINAR

truly repository injectable B_{12}

quickly achieves and sustains high B_{12} blood levels for a minimum of 28 days



The Depinar special repository base permits slow absorption from the injection site, thus decreasing the need for frequent administration. Depinar continually bathes the tissues in vitamin B_{12} to provide more effective therapy and make patients feel better longer. A recent clinical report* shows over 98% of Depinar is retained after one week . . . and "Serum level vitamin B_{12} . . . sustained for 28 days or more from the single dose."

Each package of Depinar consists of a multiple dose vial, containing cyanocobalamin zinc tannate (lyophilized) equivalent to 2500 mcg. vitamin B_{12}. The vial of diluent contains 5 cc. Sodium Chloride Solution for Injection. When reconstituted, each ml. of Depinar contains 500 mcg. vitamin B_{12}.

*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

ARMOUR PHARMACEUTICAL COMPANY • KANKAKEE, ILLINOIS

Armour Means Protection

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ARMOUR



If she needs nutritional support . . . she deserves

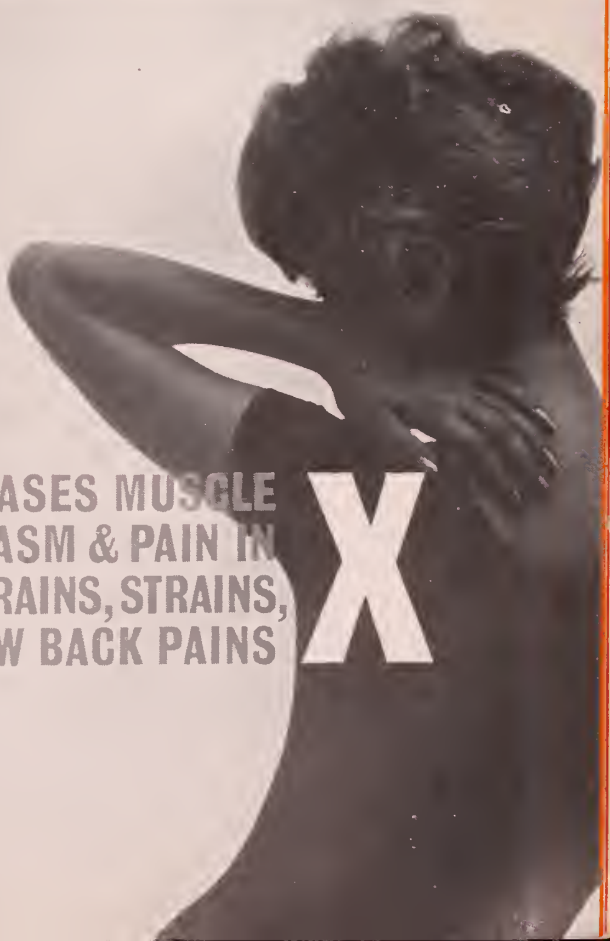
GEVRAL®

Vitamin-Mineral Supplement Lederle

CAPSULES—14 VITAMINS—11 MINERALS

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York

Lederle



OUNCING
ERING'S
NEW
OGESIC[X]

RELA™ X

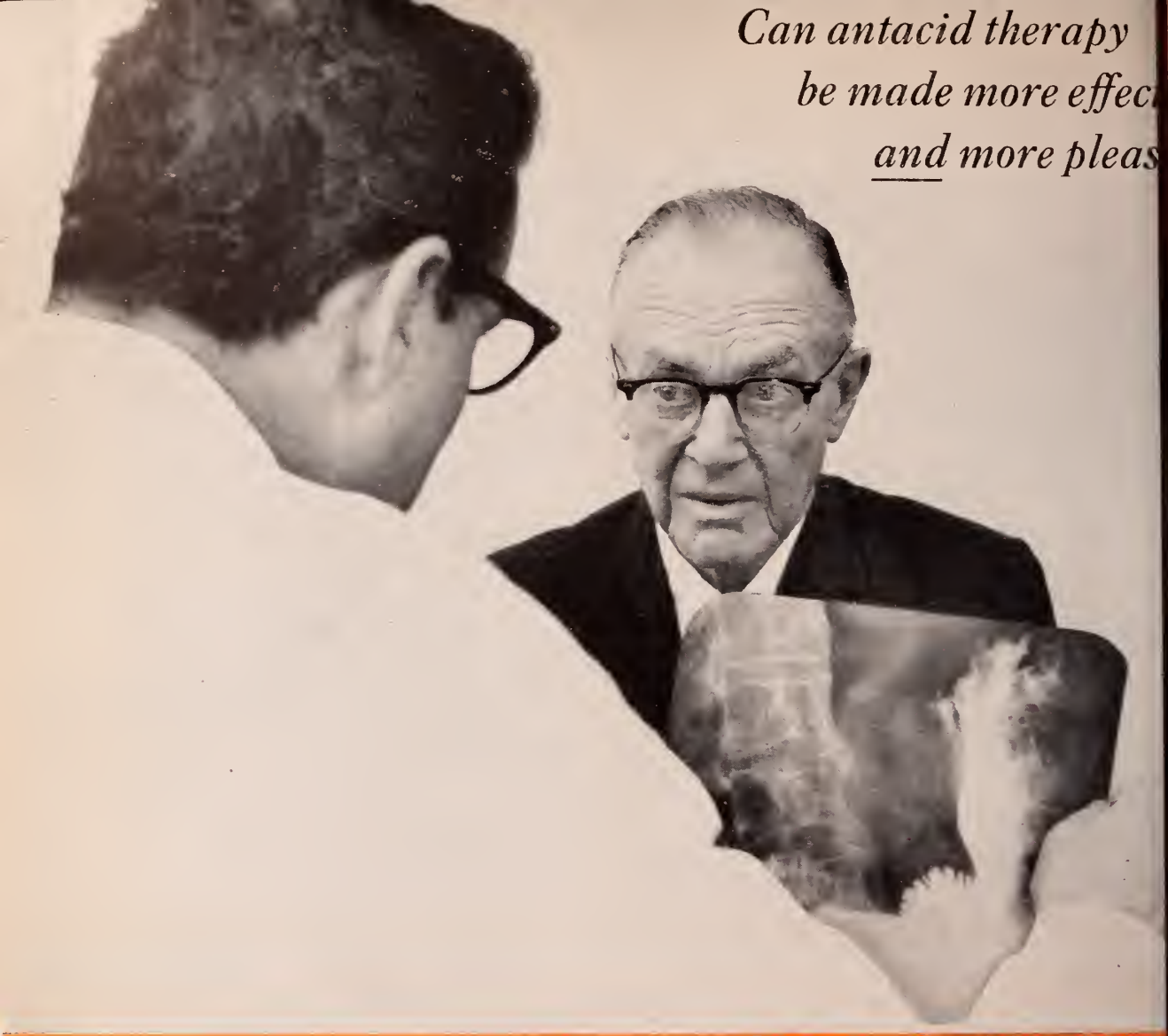
-EASES MUSCLE SPASM & PAIN IN SPRAINS, STRAINS, LOW BACK PAINS

CARISOPRODOL

[X]**MYOGESIC**
muscle analgesic

Schering

Can antacid therapy
be made more effec
and more pleas



THE MOST SIGNIFICANT IMPROVEMENT IN ANTACID THERAPY SINCE THE INTRODUCTI OF ALUMINUM HYDROXIDE IN 1929

NEW

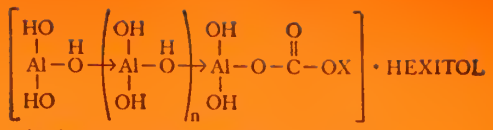
Creamalin®

ANT
TAB

Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, shor mer dried aluminum hydroxide gel, (stabilized with hexitol), with 75 mg. magnesium hyd

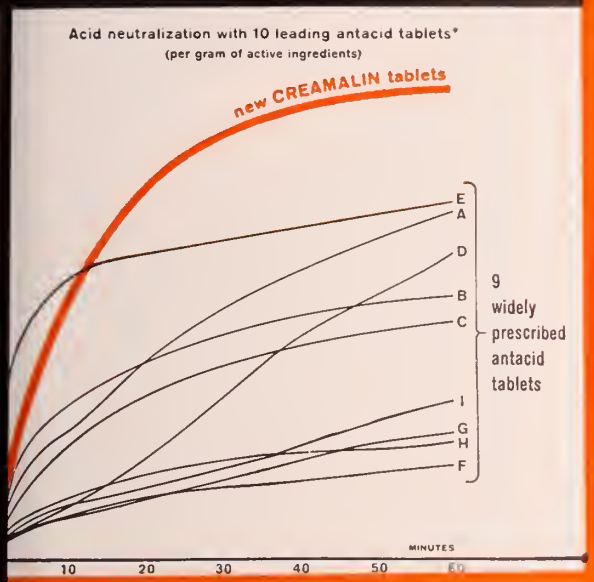
1. *Neutralizes acid faster (quicker relief)*
2. *Neutralizes more acid (greater relief)*
3. *Neutralizes acid longer (more lasting relief)*
4. *No constipation • No acid rebound*

ew high in effectiveness
d palatability



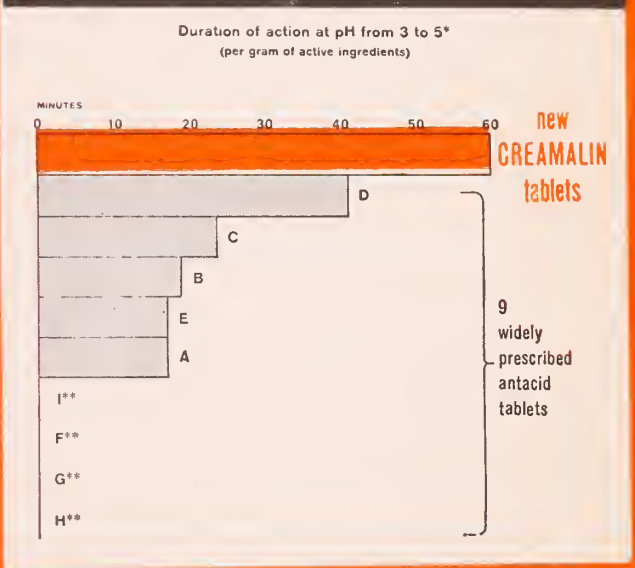
n is at least 1 and averages less than 6. X is a cation.

AMALIN NEUTRALIZES *MORE* ACID *FASTER*
Quicker Relief • Greater Relief



ets were powdered and suspended in distilled water in a constant temperature ner (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric was added as needed to maintain pH at 3.5. Volume of acid required was rded at frequent intervals for one hour.

CREAMALIN NEUTRALIZES *MORE* ACID *LONGER*
More Lasting Relief



*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.





No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

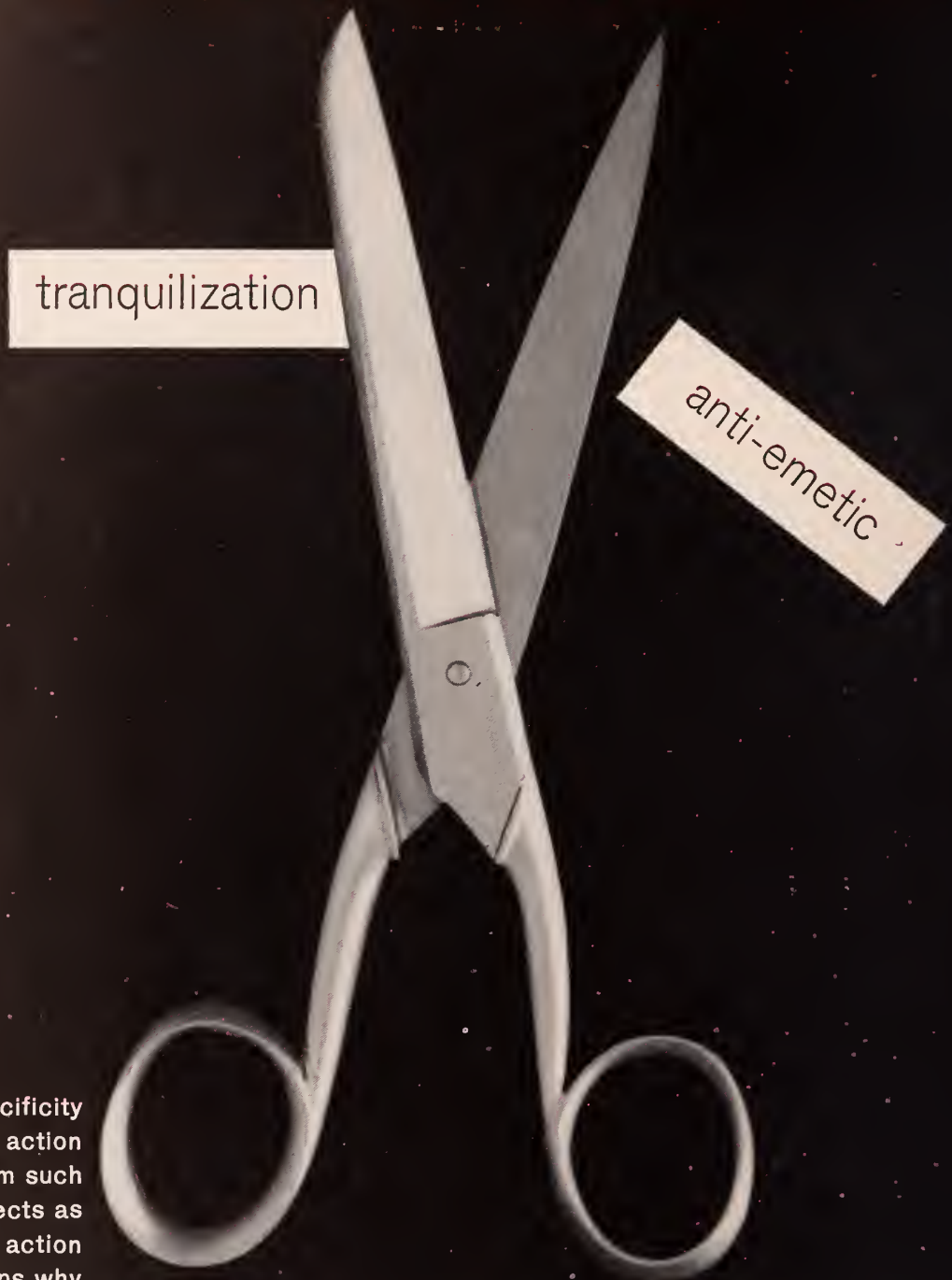
• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

Winthrop LABORATORIES • NEW YORK 18, NEW YORK

NOW... SAFER, EFFECTIVE TRANQUILIZER THERAPY



greater specificity of tranquilizing action —divorced from such "diffuse" effects as anti-emetic action —explains why

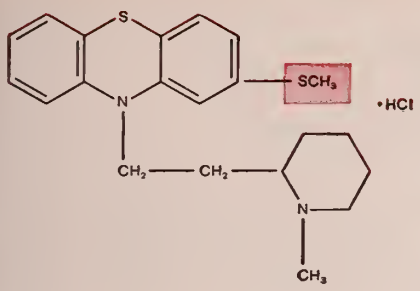
Mellaril®

THIORIDAZINE HCl

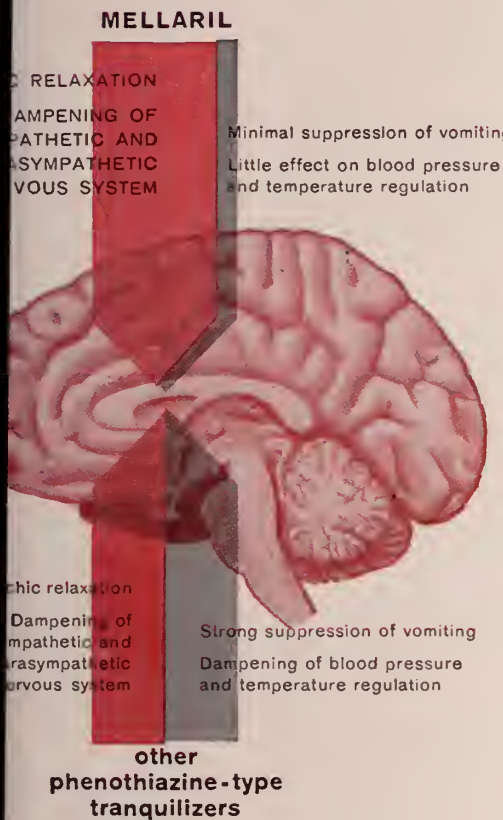
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines.... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

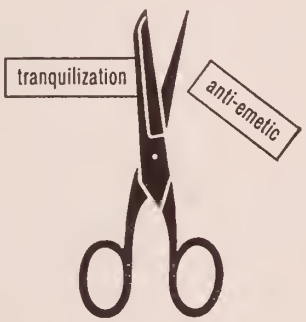
w advance in tranquilization:
ater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical (S·CH$_3$) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

LARIL Tablets, 10 mg., 25 mg., 100 mg.

A. M.: Scientific Exhibit, American Academy
ral Practice, San Francisco, April 6-9, 1959

SANDOZ

STEREO
WEBCOR



WEBCOR REGENT CORONET
STEREO HI-FI TAPE RECORDER

$329.95

- Will record and ploy back both stereo and monaural tapes
- Provides 2-channel and 4-channel stereo playback
- Dual-channel 16-watt omplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directional microphones
- In ebony with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,
INCORPORATED

457 CHANCELLOR AVENUE **NEWARK, N. J.**

Why should I use **KANTREX**® Injection* when there are so many other antibiotics available?

Because KANTREX Injection is bactericidal to a wide variety of organisms, including many that are highly resistant to the other antibiotics[4,4,10,12,13,17,18,20,21,23,24,25,27,30,33,35,37]

—organisms such as *Staph. aureus, Staph. albus, A. aerogenes, E. coli, H. pertussis, K. pneumoniae, Neisseria* sp., *Shigella, Salmonella* and many strains of *B. proteus.*

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it also?*

Next page, please . . . . . .

* Kanamycin sulfate injection (Bristol)

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it also?*

A A very good question, but it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

Q *My impression is that* KANTREX *is just another neomycin. Isn't that so?*

A Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"[1]; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

Q *You mean that* KANTREX *Injection doesn't have the nephrotoxicity of neomycin?*

A Precisely. It's true that when KANTREX Injection is used, urinary casts — even slight albuminuria or microscopic hematuria — may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

Q *Then why do you recommend reduced dosage in patients with renal impairment?*

A Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

Q *Is that why we see reports of patients developing hearing loss during* KANTREX *Injection therapy?*

A Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can be achieved with a fraction of the dose suggested for patients with normal kidney function — with minimal risk of ototoxicity.

Q *Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use* KANTREX *Injection in such conditions?*

A Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus, A. aerogenes* and *E. coli*, even when renal impairment is present.

Q *What are the "proper precautions" in a patient with impaired renal function?*

A The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more

QUESTIONS ON THE CLINICAL USE OF KANTREX

is seldom required because the clinical response to KANTREX Injection is so rapid.

Q Why do you put so much emphasis on KANTREX's "rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."

A There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.[1,2,3,5,8,9,11,14,16,19,21,23,26,29,32,33] Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[2,9]

Q Does KANTREX Injection cause blood dyscrasias?

A In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

Q Can I administer KANTREX Injection in any other way than by the intramuscular route?

A Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

Q So you think I ought to use KANTREX Injection as my first choice antibiotic in staph and gram-negative infections?

A Yes — because all evidence to date indicates that it is bactericidal against a wide range of organisms... rapid acting... does not encourage development of bacterial resistance... is well tolerated in specified dosage... and has not caused any blood dyscrasias.



KANTREX CAPSULES

for local gastrointestinal therapy... not for systemic infections

Q Why can't I use KANTREX Capsules for systemic medication?

A Because there is only negligible absorption of KANTREX from the gastrointestinal tract.[3,5,6,8,28,34] Thus, capsules cannot provide effective blood levels.

Q Then what are KANTREX Capsules used for?

A Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q I've been using neomycin for preoperative bowel sterilization. Why should I switch to KANTREX Capsules?

A Because KANTREX has been rated as "superior to neomycin" for this purpose.[6] It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.[5,6]

Q What advantages do KANTREX Capsules offer me in the treatment of intestinal infections?

A A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella, Shigella, Staph. aureus, E. coli* and *Endamoeba histolytica*. Moreover, their use has been "remarkably free of any side effects."[31]

KANTREX

INJECTION KANAMYCIN SULFATE INJECTION

INDICATIONS
Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives"; genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and periostitis.

DOSAGE: INTRAMUSCULAR ROUTE
Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

TOXICITY
When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

OTHER ROUTES OF ADMINISTRATION
KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

PRECAUTIONS
Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

SUPPLY
Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.
KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

CAPSULES (for local gastrointestinal therapy; not for systemic medication)

INDICATIONS AND DOSAGE
For preoperative bowel sterilization: 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

PRECAUTION
Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

SUPPLY
KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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HOW KENT BLAZED THE TRAIL TO LOW TAR AND NICOTINE CONTENT



A major independent research foundation, under Lorillard sponsorship, determined that the average puff of cigarette smoke contains over 12 billion semi-solid particles. Further research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, averaging 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the extraordinary Kent filter, the fibers are mechanically manipulated in such a manner as to create a multitude of baffles and extremely tortuous passageways for the smoke. This is the "Micronite" Filter.

Lorillard pioneered research into filtration—creating a filter of extraordinary ability to decrease smoke solids. So—from the very start—Kent blazed the trail to the lowest level of tars and nicotine among all leading brands. And today, tars and nicotine are at the lowest level in Kent's history.



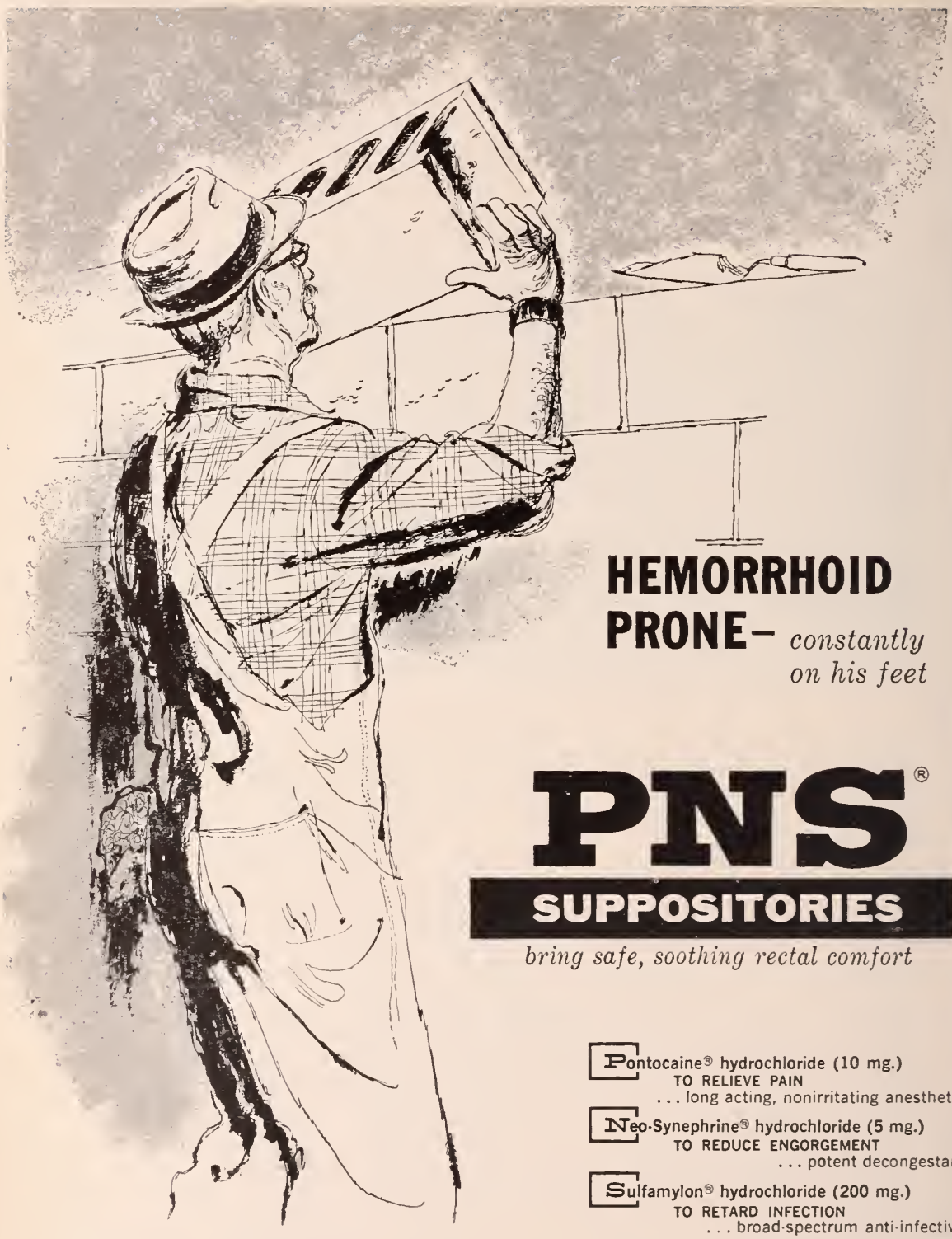
This Kent achievement in the field of filtration was done without sacrifice of rich tobacco flavor. Kent uses only 100% natural tobaccos—the finest in the world today—to give you real tobacco taste. Kent satisfies your appetite for a real good smoke.

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A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!



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bring safe, soothing rectal comfort

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TO RELIEVE PAIN
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Directions:
1 suppository rectally after each bowel movement and on retiring.

How Supplied:
Boxes of 12.

As an added measure to promote rectal comfort while correcting bowel atonicity, add MUCILOSE®-SUPER to the patient's diet. This lubricating, nonirritating bulk laxative and stool softener will encourage easy, regular evacuation.

PNS, Pontocaine (brand of tetracaine), Neo-Synephrine (brand of phenylephrine), Sulfamylon (brand of mafenide) and Mucilose, trademark, reg. U. S. Pat. Off.

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Phenyltoloxamine DHC 50 mg. Mild, non-phenothiazine, safe with a low sedative component. Seemingly specific for control of the type anxiety seen in asthma.

Usual Dose: *Adults:* For the attack, one or two tablets.
Prophylactically, one tablet every four hours
Children: (6 to 12 years) One-half the adult dose.

1. Miller, H., and Baruch, D.: Practice of Psychosomatic Medicine as Illustrated in Allergy, Blakiston Company, 1956. 2. Swartz, H: Ephoxamine in the Symptomatic Treatment of Bronchial Asthma, Current Therapeutic Research, 1 (Nov.) 1959.

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SYMPOSIUM REPORT:

ALTAFUR in antibiotic-resistant staphylococcal infections

ALTAFUR proved superior to any other single agent against staphylococcal infections encountered in the pediatric section of a general hospital. Introduced during an epidemic of severe staphylococcal pneumonia and bronchiolitis in younger children, ALTAFUR was employed in treating a total of 59 infants or juvenile patients, most of whom had upper or lower respiratory tract involvement. Almost all had been given antibiotics without effect; 34 were judged severely or critically ill. Cures were obtained in 54 of these patients after a 3 to 10 day course of ALTAFUR. There was only one failure (results were inconclusive in the remaining four cases). Mixed infections with Pneumococcus or Streptococcus sp. also responded readily.

ALTAFUR was administered orally in varying dosage: the optimal dose is believed to be about 22 mg./Kg. daily.

Side effects were minimal in these patients, being limited to gastric intolerance in a few cases, usually controllable by giving the drug with or after meals. Laboratory studies performed before and after ALTAFUR treatment revealed no adverse influence on renal, hepatic or hematopoietic function, nor other signs of toxicity.

In vitro, staphylococci isolated in this series proved uniformly susceptible to ALTAFUR, whereas many strains were resistant to a variety of antibotics. With ALTAFUR as with all nitrofurans, the lack of development of significant bacterial resistance is considered a major advantage over other antimicrobials.

Lysaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academics of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

bright new star

in the antibacterial firmament

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brand of furaltadone

the first nitrofuran effective orally

in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
- Sensitivity of staphylococci in vitro (including antibiotic-resistant strains) has approached 100%
- Development of significant bacterial resistance has not been encountered
- Low order of side effects
- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

Tablets of 50 mg. (pediatric) and 250 mg. (adult)
Average adult dose: 250 mg. four times a day, with food or milk
Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily in 4 divided doses

CAUTION: The ingestion of alcohol in any form, medicinal or beverage, should be avoided during Altafur therapy.

NITROFURANS—a *unique* class of antimicrobials
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when a tranquilizer is warranted



The extended usefulness of TENTONE is readily apparent

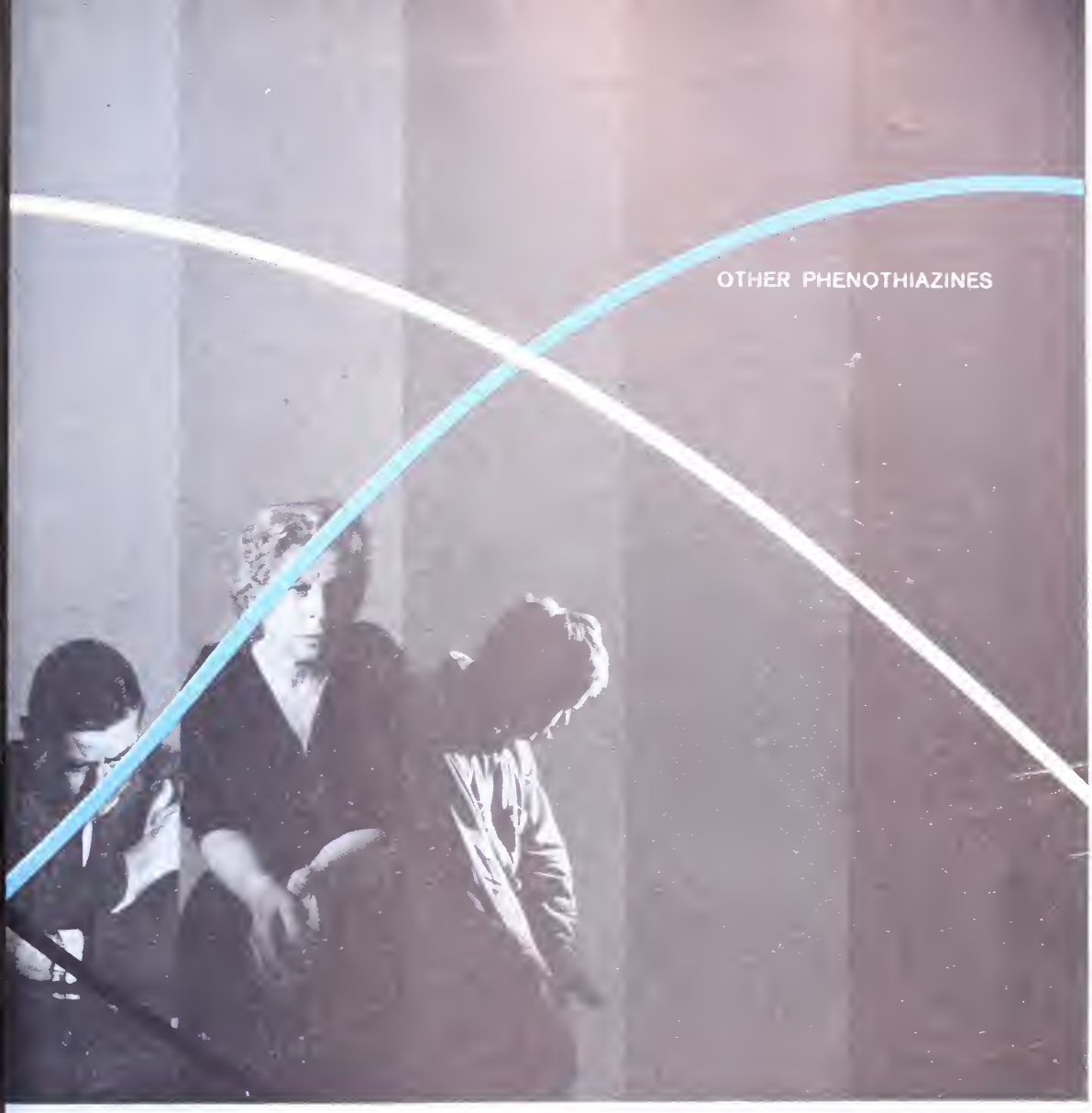
TENTONE® Methoxypromazine Maleate is a new, distinctive phenothiazine . . . highly active . . . for general use in mild and moderate emotional and psychosomatic disorders.

TENTONE elicits a striking, positive calming response[1,2] . . . with marked reduction of psychic disorientation, and low risk of blood, liver or other organic toxicity and intolerance.[1-4]

TENTONE parallels the weaker ataractics in low incidence of side effects. Freedom from induced depression is apparently even greater.[5]

TENTONE provides a broadly adaptable dosage range (30 to 500 mg. daily) to permit maximum control in cases of varying severity.

TENTONE is also indicated to relieve emotional stress in surgical, obstetric and other hospitalized patients.



CONDITION

sage: Mild to moderate cases—average starting dose, one 10 mg. or one 25 mg. tablet ee or four times daily. *Moderate to severe cases*—average starting dose, one 50 mg. tablet r times daily. *Supplied:* 10 mg., 25 mg., and 50 mg. tablets.

Bodi, T., and Levy, H. Clinical [illegible] Warner, R. V., and Phillips, R. M. Clinical rt, cited with permission. 3. Perry, V. Clinical [illegible] and Gastric Function. *Am. J. Psychiat.* 939 (April) 1959. 5. Dorvey, S. F. C. Clinical [illegible]

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Tetracycline-Triple Sulfa Combination (TETREX® c T/S) in the Treatment of INFECTION

It is generally agreed that it is ideal to withhold antibiotic and chemotherapeutic drugs until after sensitivity tests show which antibacterial agent will be most effective. But very often, in actual practice, the physician knows that delay in starting antibacterial treatment may be detrimental to the welfare of his patient. He must then select the therapy to meet the most serious and immediate threats to the patient.

Why Combination Therapy?

Certain infections do not respond as well to a single agent as to a combination. *Hemophilus influenzae* infections, which are frequent in children, are a particularly serious threat to infants and children up to about 3 or 4 years of age since they have not yet built up any appreciable immunity. Serious complications such as influenzal pneumonia, empyema, or meningitis may develop, especially in this age group. In fact, except for those periods when meningococcal meningitis is epidemic, *H. influenzae* is the most frequent cause of meningitis.[1] This gram-negative organism is highly susceptible both to the tetracyclines and to the sulfonamides. Even in severe infections, therapeutic failure can be virtually eliminated by giving sulfonamides plus tetracycline.[1] These two agents together constitute the treatment of choice, and give better results than either alone.[2]

Sulfonamides remain the drugs of choice for all meningococcal infections, including meningitis. They readily penetrate the blood-brain barrier and pass into the cerebrospinal fluid in good concentrations.[3] In treating overwhelming meningococcal infections, and complicating infections of the upper respiratory tract caused by other organisms, the addition of tetracycline to sulfas can be valuable.[4]

In recent years the sulfonamides have again been prescribed more and more frequently. In certain serious infections, better results can be obtained with a combination of antibiotic and sulfonamide than with either drug alone (e.g., severe pneumococcal pneumonia or pneumococcal meningitis[5]). Furthermore, mixed infections, to which young children are particularly susceptible, often respond only to combination therapy such as tetracycline with sulfonamides (TETREX c T/S).

Why Triple Sulfas?

Some sulfonamides, though therapeutically useful, frequently crystallize and cause renal damage. Sulfonamide mixtures are designed to prevent this effect. It is known that different substances can coexist in solution without interfering with each other's solubility. In such a solution each component behaves as if it alone were present. Thus, a much larger total amount of sulfonamide can exist in the urine without precipitating if a mixture is administered than if the same amount of only one compound is given.

Similarly, there is less danger of hypersensitivity with mixtures. The incidence of sensitization varies directly with the dosage and is limited to the particular sulfa given. Simultaneous use of several sulfa compounds, each in partial dosage, tends to keep each drug below its own sensitization level.[3] As with all sulfonamides, it is advisable to check for possible blood dyscrasias, rash, or renal toxicity during extended administration.

TETREX c T/S, by combining only 167 mg. each of sulfadiazine, sulfamerazine, and sulfamethazine, practically eliminates serious renal damage and sensitization reactions due to sulfonamides while retaining the therapeutic efficacy of the total dose.

TETREX c T/S can be administered with confidence in all severe and mixed infections due to tetracycline-sensitive and sulfonamide-sensitive organisms, including infections of the upper respiratory, urinary, and gastrointestinal tracts.

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TETREX® c T/S

Antibiotic-triple sulfa combination in a palatable, cherry-flavored syrup.

Each 5 ml. teaspoonful contains:

Tetracycline (ammonium polyphosphate buffered equivalent to tetracycline HCl activity)	125 mg.
Sulfadiazine	167 mg.
Sulfamerazine	167 mg.
Sulfamethazine	167 mg.

This suspension may be stored at normal room temperature.

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Striking relief
from LOW BACK PAIN
and DYSMENORRHEA

THE FIRST TRUE TRANQUILIZER

Trancopal

THE FIRST TRUE "TRANQUILAXANT"

Trancopal

potent MUSCLE RELAXANT

effective TRANQUILIZER

- In musculoskeletal disorders, effective in 91 per cent of patients.[1]
- In anxiety and tension states, effective in 89 per cent of patients.[1]
- Low incidence of side effects (2.3 per cent of patients). Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications [1-6]

Musculoskeletal:

Low back pain (lumbago, etc.)
Neck pain (torticollis)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow
Myositis
Postoperative muscle spasm

Psychogenic:

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism

Now available in two strengths:



Trancopal Caplets®,
100 mg. (peach colored, scored), bottles of 100.

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Trancopal Caplets,
200 mg. (green colored, scored), bottles of 100.

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Winthrop LABORATORIES
New York 18, N. Y.

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rapid even coverage on eye, lids, fornices . . . resists dilution by lacrimation . . . maintains effective antibiotic concentrations

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rapid suppression of common cocci and bacilli and of susceptible viruses whether the primary infection or a complication of irritation, trauma, or inflammatory disease . . . fast resolution of swelling, erythema, and lesions . . . excellently tolerated

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RELAXES THE SPASTIC G. I. TRACT **RELIEVES NAUSEA IN PREGNANCY**

Provides superior anticholinergic-antitensive action through smooth, consistent and prolonged release of drugs over a 10 to 12 hour period.

The rate of release is independent of location in the gastrointestinal system—the same rate in **ACID** *or* ***ALKALINE*** *media.*



DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

*LEMMON Brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

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DECADRON—the new and most potent of all corticosteroids, **eliminated fluid retention in all but 0.3 percent of 1500 patients†, and induced beneficial diuresis in nearly all cases of pre-existing edema.**



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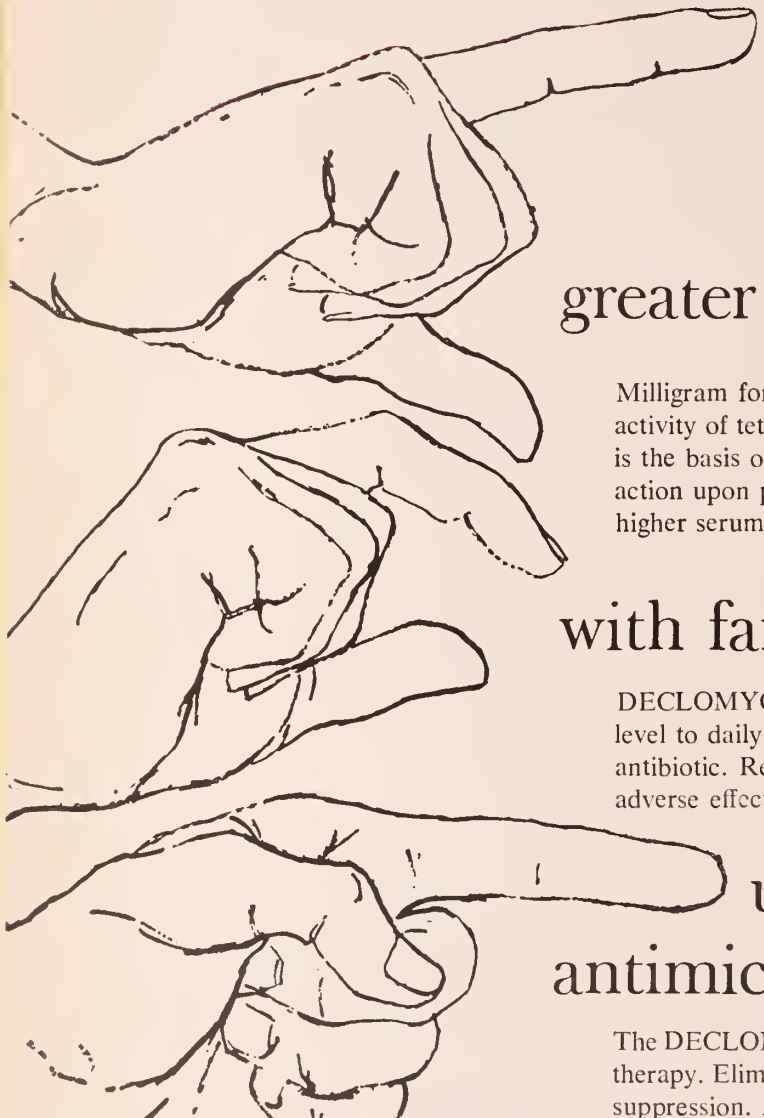
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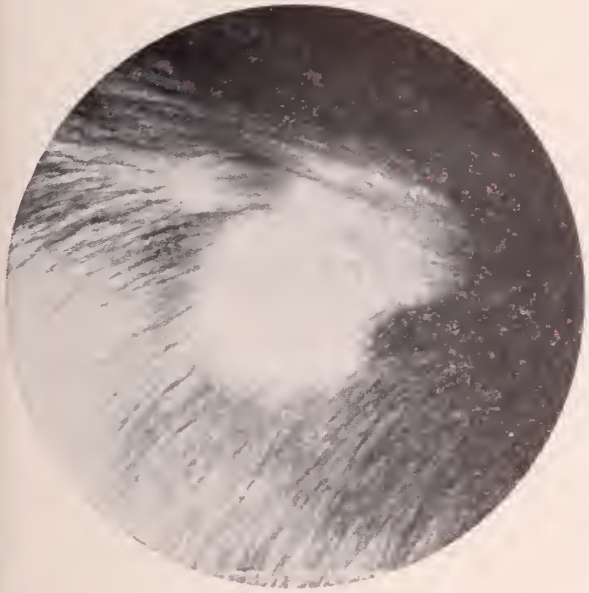
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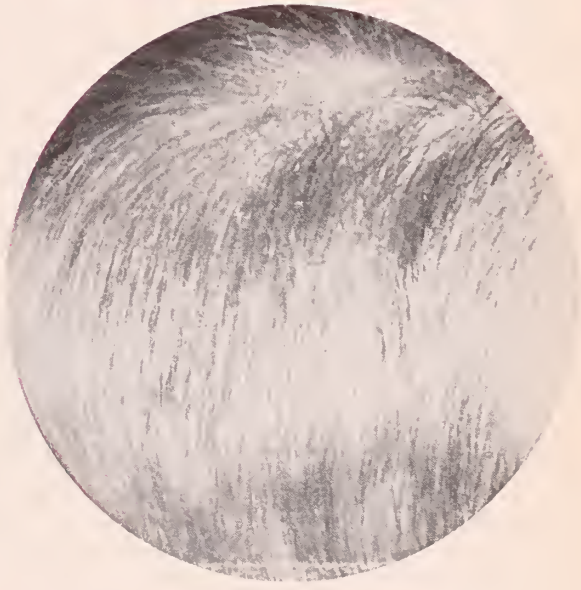
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1. Robinson, H. M., Jr., *et al.*: Griseofulvin, Clinical and Experimental Studies, A.M.A. Arch. Dermat., in press.

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Editorials • • •

Hospitalizing the Alcoholic

The acutely drunken person is not a glamorous figure. Doctors don't like to be called to rescue a drunk from a hotel room or a police station. Hospital admitting officers don't need them and don't want them. Hospital beds seem too precious to squander on someone whose illness seems to have been deliberately self-induced.

It is thus understandable that most general hospitals cold-shoulder the alcoholic. Yet we all know, in our hearts, that alcoholism is, in part at least, a medical problem and therefore a responsibility of doctors and hospitals. Nor is there any way out as easy as admitting the patient while drunk, discharging him the next day when sober. Someone must take the responsibility for the follow-up. If we doctors shirk this duty, other community resources will have to carry the burden. We are jealous when others invade our jurisdiction. Let us not forfeit it by abandonment.

The alcoholic is not a pleasant patient, but it would be a sorry profession that ignored its duty just because the illness was unpleasant.

A general hospital ought to be willing to accept patients with emotional disorders. It will take a man acutely excited in a pneumonia-induced delirium. Why not one with delirium tremens? It will accept barbiturate poisoning; why not ethanol poisoning? Medicine will extend its benefits to the thief and the murderer, never denying care because of these character defects. Why then is the alcoholic excluded?

It is good, in this connection, to note the program at the Morristown Memorial Hospital described on page 725.

We keep saying that alcoholism is sickness. If we believe this, let us treat it that way.

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The Reporting of Side Effects

Large pharmaceutical manufacturers are now emphasizing side effects and contra-indications. All reputable houses have long listed these warnings in their literature and in package brochures. But today several companies are actually issuing pamphlets which concentrate on the untoward effects of their own products. Some even release films which devote a fair amount of running time to emphasizing contra-indications. This is a heartening sign of responsibility—and a not unexpected one. While the American pharmaceutical industry has not scorned profits, it has never sought profits at the expense of misleading the medical or lay public. As drugs have become increasingly potent, their dangers have had to be emphasized. We wonder if any other sector of American business has devoted so much of its publicity to advertising the disadvantages and dangers of its own products. Cigarette manufacturers do not warn the public of the dangers of smoking. Manufacturers of sharp instruments append no caution about keeping the knives away from children. A whiskey bottle rarely carries a warning against overdosage. We cannot, at the moment, think of any other industry which tries so hard to warn against the abuse or overuse of its own products, or which actually lists possible side-effects. It is the sign of a highly responsible business enterprise.

The Doctrine of Causation

One of the sources of dispute between physicians and attorneys is that "proximate cause" (lawyer's jargon) does not mean "cause" in the medical (hopefully, *scientific*) sense. For instance, a court once held a hand injury to be the proximate cause of a disability due to paresis. The man had had syphilis, but had no mental symptoms. After the hand injury, he brooded about being "a cripple," plunged into a psychosis, and had to be hospitalized. The Court's reasoning was that worry about the crippling precipitated the psychosis out of the luetic soil. This, in a legal sense, is a perfectly sound example of "proximate cause" though most doctors would scorn it.

If this legal concept of "cause" is too loose, our medical concept may be too narrow. We demand the fulfillment of something like Koch's postulates before we accept causation. Then we assume that we have established a sufficient cause. For instance, we take it as an article of faith that the tubercle bacillus causes tuberculosis or that alcohol causes delirium tremens. Yet only a small proportion of those harboring the tubercle bacillus get clinical phthisis. And most people who get drunk never see pink elephants. You need the bacillus *plus something* or the alcohol *plus something* in order to get clinical disability. Or, as Jonathan Forman neatly puts it: "Ragweed is no more the cause of hay fever than a gun is the cause of murder." The psychosomatic doctrine is another illustration. Hyperacidity plus hypermotility causes peptic ulcer . . . or does it? You need an emotional factor too.

The quest for a single cause is understandable. It makes everything simpler if we can blame some one single factor for delinquency, divorce, disease, war or crime. But we will have a more mature grasp of the development of disease if we absorb the doctrine of multiple causation. Things are just never simple. The hard way, unfortunately, is often the only true way.

DANIEL E. KAVANAUGH, M.D.

Newark

Tendinitis and Peritendinitis*

Nonspecific Forms in Rheumatic Disease

In the management of rheumatic disease, one of the annoying by-products may be the development of a nonspecific tendinitis or peritendinitis. Dr. Kavanaugh here offers a practical approach to this series of disorders.

NON-SPECIFIC tendinitis† and peritendinitis, occurring in the course of a rheumatic disease, are brought about by several mechanisms. They may be caused by the underlying disease itself, by trauma or by factors related to the abnormal amount of time spent in bed. The bed-ridden patient with his weakened musculature frequently places undue strain upon muscles and tendons by his effort to change his position in bed. He may reach overhead to grasp the head of the bed to pull himself up; or he may exert leverage on his elbows and by abnormal use bring about not only the change of position but also undue strain on shoulder tendons. The patient's tendency to be too active or too forceful in the use of his hands can bring about pathologic tendon conditions. He may unwisely continue to play the piano or to use the typewriter; or the patient, usually female, continues to crochet or to do other forms of needlework which can be harmful. These items of hand activity are probably most harmful to patients whose metacarpophalangeal joints are swollen. In such cases the extensor mechanism of the fingers may be severely damaged.

Because the literature on the subject of this paper presents a rather impressive lack of uniformity in the use of terms, I have ventured to formulate a classification of the nonspecific forms of tendinitis† and peritendinitis. This is offered as a basis for univocal interpretation of terminology in the hope of lessening the equivocal interpretation which is found in current literature. Inasmuch as this classification is based chiefly upon anatomic considerations, I will review certain aspects of the anatomy of tendons.

In most cases skeletal muscles are attached by the tendons of origin and insertion to bone.[1] Some of the fibers of these tendons blend with the periosteum but a great many fibers penetrate the cortex of the bone and thereby obtain greater fixation to withstand the pull of muscle fibers. If the muscles have fleshy attachment to bone, the muscle fibers have microscopic tendinous ends which blend with the periosteum.

The tendon of insertion of the *tibialis anticus* muscle is a suitable model of the tendons of our extremity muscles. Keep that tendon in mind during this anatomic prelude. The *tibialis anticus* tendon of insertion is housed in a rigid osteofascial tunnel formed by the deep fascia, the tibia, the fibula and the interosseous membrane. The innermost aspect of this compartment is provided with two separate and entirely different mechanisms to facilitate gliding of the tendons.[2]

*Read April 29, 1959 before the Section on Rheumatism at the Annual Meeting of The Medical Society of New Jersey.

†The spelling is correct. Although the noun is "tendon," the adjective is "tendinitis" and not, as you might suppose, "tendonitis." Reason: *tendo* is a 3d declension Latin word like *homo*; the other cases have an "i" instead of an "o", as *tendinem* or *hominem*.—Editor.

1. Brash, J. C. and Jamieson, E. B.: Cunningham's *Textbook of Anatomy*. Edition 8. Page 96. Publisher not stated. 1943.

2. Mayer, Leo: Instructional Lectures of the American Academy of Orthopaedic Surgeons 1949; "Tendon Transplantation," 6:189.

The first mechanism, the paratenon (which invests the proximal portion of the tendon) extends distally from the myotendinous junction to the superior retinaculum in front of the ankle joint. It consists of numerous elastic fibers which connect the inner surface of the fascia to the tendon. The paratenon serves as the gliding mechanism whenever a tendon moves in a straight line. The elastic fibers of the paratenon move upward and downward as the tendon moves.

The second mechanism which facilitates the gliding motion of the tendon is the synovial-lined tendon sheath. This type of gliding mechanism is found with slight modification throughout the human body wherever a tendon changes its direction and where the tendon movement may need rapid acceleration. Its function is evidently to reduce friction to a minimum.

The *tibialis anticus* tendon sheath begins immediately distal to the paratenon at a point slightly above the superior retinaculum and extends distally beneath both the superior and inferior extensor retinacula at the ankle, terminating close to the insertion of the tendon. If we open the tendon sheath, and inspect the delicate layer of paratenon (called mesotenon), on the deep or "non-friction" side of the tendon, we can see that the tendon is liberally supplied with blood *via* the blood vessels of the mesotenon. The fibers of the mesotenon must be long enough to follow the motion of the tendon. Along the friction surface of the tendon blood vessels are not found.

On the flexor aspect of the hand, the more common tendon lesions are concerned with the digital tendon sheaths of the flexor tendons. The index, middle and ring fingers are each supplied with a digital flexor sheath which extends proximally from the insertion of the profundis tendon on the proximal end of the distal phalanx and terminates in a cul de sac which is situated approximately beneath the distal crease of the hand.

On the basis of this anatomic background, I have formulated the following classification of the several categories of non-specific tendinitis and peritendinitis.

Classification of non-specific tendinitis and peritendinitis:

I. Tendinitis (inflammation of the tendon *per se*)

II. Peritendinitis (inflammation of the peritendinous tissues)

A. Paratenonitis (presented as the replacement for paratendinitis) indicates an inflammation of the tendon paratenon.

B. Tenothecitis (presented as the replacement for tenovaginitis) indicates an inflammation of the tendon sheath.

III. Stenosing tenosynovitis or stenosing tendovaginitis (inflammation of tendon combined with inflammation of its sheath)

A. De Quervain's disease.

B. Trigger finger; snapping thumb.

C. Tenostasis.

DEFINITIONS

For the purpose of this paper, I am utilizing the following definitions to describe these categories of non-specific tendinitis and peritendinitis. I use the term "athecal" meaning "without a sheath" because the word is short and the word *theca* [3-10] is a synonym for sheath. Deaver [10] used "thecitis" to identify inflammation of a tendon sheath.

Tendinitis: This word identifies a non-infectious fibrositis of the terminal athecal portions of tendons of origin, as well as of tendons of insertion, at the site of attachment to bone, frequently involving a segment of tendon adjacent to the bone. Paratenon, when present in this area, may be involved.

Peritendinitis: Meaning "inflammation of the peritendinous tissues." This is an inclusive term to apply to inflammation of the paratenon and also to inflammation of the tendon sheath.

Paratenonitis: (Currently termed "paratendinitis") This form of peritendinitis applies to a non-specific fibrositis of the elastic fibers of the paratenon. It occurs in tendons which have no tendon sheath and may also occur in the paratenon of the athecal portion of those tendons which have a tendon sheath.

3. Dorland's Illustrated Medical Dictionary. Philadelphia 1957, Saunders. Edition 23. Page 1420.

4. Lipscomb, Paul: Instructional Lectures of the American Academy of Orthopaedic Surgeons, 1959; "Nonsuppurative Tenosynovitis," 7:254.

5. Finkelstein, H.: Journal of Bone and Joint Surgery, 12:509 (1930).

6. Lipscomb, Paul: *Op. cit.*, reference 4. Page 257.

7. Phalen, G. S.: Instructional Lectures of the American Academy of Orthopaedic Surgeons 1957: "The Carpal Tunnel Syndrome," 14:142.

8. Omne, Lars: Acta Chirurgica Scandinaviva. 113:248 (1957).

9. Welply, W. R.: The British Journal of Bone and Joint Surgery, 39:794 (1957).

10. Deaver, John B.: Surgical Anatomy of the Human Body. 1926. Blakiston 2:151.

Tenothecitis: (Currently termed "tenovaginitis"). This is an acute, subacute or chronic inflammation of the tendon sheath which involves the synovial lining of the sheath. The term is not applicable to tendons or to those portions of tendons which are not provided with a tendon sheath. For example, there is no tendon sheath for the *palmaris longus* or the tendon Achilles.[4] At the *tibialis anticus* only a portion of the tendon has a sheath.

Stenosing tenosynovitis or stenosing tendovaginitis: Either term designates a chronic form of tenosynovitis combined with a chronic fibrositis of the intrathecal portion of the tendon *per se* and its mesotenon. There is usually a thickening of the tendon sheath and a constriction of its lumen. The chronic fibrositis of the tendon is the result of degenerative changes within the tendon. The degree of fibrositis depends upon the amount of functional trauma caused by the thickened tendon and its stenosing sheath; or by direct trauma. These terms are not applicable to tendons or to those portions of tendons which are not provided with a tendon sheath.

De Quervain's disease: This is a form of stenosing tenosynovitis involving the tendons of the abductor and short extensor muscles of the thumb as they cross the radial styloid process. The tendon sheath may become as much as three or four times thicker than usual while the tendons *per se* may be flattened and thinned out.

"Trigger finger" and "snapping thumb": This is a stenosing tenosynovitis characterized by a snapping and/or locking of the finger during voluntary flexion or extension of the fingers. It is caused by the thickened and constricted tendon sheath or by a prominent nodule within the tendon at the site of the cul de sac, or by both conditions.

Tenostasis: I present this term to indicate the condition of tendon fixation which prevents the gliding movement of the tendon. Although it designates the terminal stage of stenosing tenosynovitis in which the locking of the trigger finger cannot be released, it seems applicable also to the situation which prevails when the patella becomes adherent to the femoral condyle.

DIAGNOSIS AND TREATMENT

Tendinitis is basically a fibrositis of the tendon fibers. It is manifested by the symptoms of pain and tenderness at the site of attachment of the tendon to bone. Examination usually reveals that the tendon is tender not only at the point of its attachment to bone but also for a short distance from the bone. The diagnosis is assisted by having the patient maintain the tendon in a state of tension, in order that it may be more readily identified and examined for tenderness. When distinct tenderness is found, I test the corresponding tendon of the extremity of the opposite side for comparison. For the purpose of both diagnosis and treatment, I eliminate the tenderness by injecting procain, usually mixed with Meticortelone,® into the site of tendon tenderness. I then ask the patient to exercise the extremity to learn whether pain has been temporarily relieved. Complete relief of pain is commonly obtained within two or three days after the injection. Infrequently a second injection on the third day is necessary. I have found that immobilization of the joints of the upper extremity is unnecessary. Medication for the relief of pain may be indicated.

Paratenonitis (currently called paratendinitis) is an acute form of peritendinitis recognized by tenderness, swelling and, on occasion, by redness of the skin overlying the athecal portion of the tendon involved. This segment of the tendon corresponds roughly to that portion of the tendon which is *not* situated beneath a retaining retinaculum. Crepitation upon motion of the tendon may occasionally be felt in this area. The treatment of paratenonitis is quite similar to, and will be taken up under the treatment of tenothecitis.

Tenothecitis (currently called tenovaginitis) is diagnosed by the presence of pain, tenderness and swelling in the region of the thecal portion of the tendon as well as by the occasional redness of the overlying skin. In the chronic and sub-acute stage, it is possible that crepitation can be felt.

Immobilization of the tendon and constant wet dressing may cure the early stage of this condition. Many patients respond to local applications of the old counter-irritant, capsicum

petrolatum" or Capsolin® (Parke-Davis). When hand and fore-arm tendons are involved, a molded plaster splint is probably the best form of immobilization. In the lower extremities, in addition to wet dressings, it may be desirable to stop all weight bearing. I find injection of Hydrocortone® or Meticortelone® helpful.

In patients who do not respond to the treatment just described, diathermy and other forms of physical therapy may be used. X-ray therapy is indicated in the more severe cases.

De Quervain's disease commonly develops as a result of trauma or of unnatural or excessive use of the tendon. The condition is diagnosed by pain, tenderness and swelling in the region of the radial styloid process. A helpful diagnostic procedure is Finkelstein's test.[5] This is done by grasping the involved thumb and forcing the wrist into ulnar deviation. This causes sharp pain in the region of the styloid process of the radius.

In the early stage of De Quervain's disease, complete relief has been obtained by splinting the thumb in the position of abduction and by the injection of procaine and Meticortelone® into the tendon sheath. When this has been unsuccessful, x-ray therapy has sometimes given relief. On the basis of published reports,[6] some have been able to keep the number of cases requiring surgery down to a level of 35 per cent. Surgical relief is accomplished by incising the abnormally thickened portion of the sheath, extending the incision well into the normal tissue both proximally and distally. At times it is necessary to remove a section of the thickened portion of the tendon sheath at the point of constriction. When anomalous accessory tendons are found at the site of the lesion, some surgeons remove these tendons and some do not. I remove them. In general, the results of surgical treatment of this condition are gratifying both to the patient and to the doctor.

"Trigger finger" and *"snapping thumb"* are readily diagnosed by the fact that the patient complains of a painful locking of the finger or the thumb in the position of flexion or extension and also of some difficulty as well as pain in restoring the finger to its previous position. When this condition is seen sufficiently early, adequate immobilization of the finger in the position of semiflexion for four to eight weeks may be enough to cure it. When conservative treatment is unsuccessful, surgical relief is accomplished by a short transverse incision paralleling the distal crease of the palm over the metacarpophalangeal joint. The dissection is carried down to expose the tendons, the transverse band and the enlargement of the flexor sublimis tendon. The thickened portion of the tendon sheath is incised on the lateral side of the tendon rather than on its gliding surface. If it is found that the tendon still does not glide freely, the surgeon will incise the thickened sheath on the opposite side of the tendon. If a nodule is found within the tendon, it is removed.

In managing a case of "trigger finger" or "snapping thumb," the doctor gives consideration to the fact that surgery affords positive and prompt relief. On the other hand, immobilization of the finger or thumb by splinting may be a matter of six or eight weeks with three possible results:

1. A cure may have been effected.
2. The condition may recur.
3. Surgery may still be necessary.

In *tenostasis* due to irreversible locking of the finger or thumb in flexion, the decompression surgery above described is indicated. When tenostasis is the result of firm fixation of the patella to the femoral condyle, it can be relieved by excision of the patella.

CARPAL TUNNEL SYNDROME

IN RECENT years there has been an ever-increasing interest in the carpal tunnel syndrome which, in most cases, is *caused* by nonspecific tenosynovitis of the tendons passing through the carpal tunnel.[7] The symptom picture is, presumably, the result of an ischemia of the median nerve caused by compression of this nerve against the transverse carpal ligament. In the carpal tunnel the median nerve lies immediately beneath the transverse carpal ligament and on top of the flexor tendons of the wrist. It cannot escape pressure against

this ligament whenever space-occupying changes or space-altering changes occur in this rigid osteofascial tunnel.

In addition to non-specific tenosynovitis, the etiologic factors include ganglia, lipomata, hemangiomas and fractures in the region of the carpal tunnel. Acromegaly has also caused it.

Although the *pathogenesis* of this non-specific tenosynovitis has not been definitely established, some authors[7,8] believe that it has a rheumatic or rheumatoid origin.

The *symptoms* conform to the distribution of median nerve components distal to the wrist joint and are as follows:

1. Pain, paresthesia and hypesthesia in the median nerve distribution of the hand. Pain and numbness following strenuous use of the hand may be delayed for several hours after the manual activity. Pain at night may be severe enough to prevent sleep.
2. Atrophy of the thenar muscles is usually limited to the opponens, the short flexor and short abductor of the thumb. The ulnar nerve may supply some or all of the thenar muscles which are usually supplied by the median nerve. The atrophy is more readily observed when the profiles of the two thenar eminences are compared.

The *diagnosis*[7] is made on the basis of:

1. A history of the above symptoms.
2. A positive Tinel sign. This is a tingling sensation radiating out into the hand following light percussion over the median nerve at the wrist.
3. A positive wrist flexion test. Prompt exacerbation of numbness and paresthesia in the median nerve distribution in the hand occurs when the patient maintains the wrist in complete flexion for approximately sixty seconds. Prompt improvement in these symptoms occurs when the wrist is returned to a neutral position.
4. A positive wrist extension test. The same symptoms may develop if the patient maintains the wrist in complete extension for a period of sixty seconds.
5. A positive cuff test. Increased pain and paresthesia in the median nerve distribution are produced by inflating a blood pressure cuff, applied to the arm, to a point above the systolic pressure and maintaining this level of pressure for about two minutes. Thereafter the pressure level is reduced to between systolic and diastolic pressure. The ischemia produced by the tourniquet often will produce an aggravation of symptoms within a few seconds.[9]
6. A strict limitation of all objective sensory findings to the median nerve distribution distal to the wrist.

The patient's symptoms of pain and paresthesia may be readily relieved by sectioning the transverse carpal ligament to decompress the median nerve in the carpal tunnel. The prognosis of muscle paralysis of more than one year's duration is not good.

The operation is done under general anesthesia and in a bloodless field. A transverse incision, one to one and a quarter inches long, may be extended proximally at its medial end or distally at its lateral end if this is necessary for more complete exploration. Once the transverse carpal ligament has been exposed, the surgeon is careful to incise it on its medial aspect to avoid damage to the recurrent branch of the median nerve. Only rarely is a partial synovectomy also necessary to decompress the nerve adequately.

Local injections of hydrocortisone or Meticortelone® may relieve the symptoms in some cases without resorting to surgical treatment; but in many cases the symptoms ultimately return.

Early recognition is infrequent. Among a group of patients seen during an eight year period, only 24 per cent of seventy-one cases presented symptoms of less than six months when first seen. For the remaining 76 per cent the duration of symptoms was six months to thirty years. In three cases the duration was actually more than 20 years!

My experience with this syndrome is limited to one case, a 38-year old woman. The diagnosis was suspected five months after the onset of symptoms which developed during a viral infection which had caused cervical meningitis, ganglionitis, peripheral neuritis and a transitory cardiac insufficiency. She had acute pain and tenderness of the soft tissues of the forearm and a vesicular eruption on the ulnar aspect of the wrist. Median nerve symptoms in the hand developed within the first week of the viral infection. There was weakness of abduction of the thumb. Because of hyperalgesia, she could not allow her fingers to touch any surface including the bed clothing. The symptoms, at first intolerable, became less severe in the succeeding months but there were occasional acute exacerbations. Injection of Meticortelone® into the carpal tunnel gave no relief. I performed a surgical decompression of the median nerve six months after onset. Because the opposite upper extremity was incorporated in a spica for treatment of a fractured humerus and because of other factors, I did not explore the median nerve and flexor tendons surgically. Symptomatic relief was prompt and almost complete. She has only a slight vestige of numbness of the tip of the middle finger.

SUMMARY

THIS paper directs attention to conditions of non-specific tendinitis and peritendinitis which may develop during the course of management of rheumatic disease. In the interest of clarity of terminology and standardization in the use of terms, applicable to non-specific lesions, a classification of the several categories of non-specific tendinitis and peritendinitis has been presented. Some of the details of the diagnosis and treatment of the conditions listed in the classification have been outlined.

A brief resume of the carpal tunnel syndrome or compression neuropathy of the median nerve (which in the majority of cases is caused by non-specific tenosynovitis) has also been presented.

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As a general rule, an AMA attorney observed, the physician who takes it upon himself to exceed the dosages recommended by the manufacturer may be risking the safety of his patient and the possibility of a malpractice suit.

There have been instances in which time has proved that the recommendations of the manufacturer could have been exceeded without harm to the patient. Some firms fail, or are slow to change their labeling to reflect advanced knowledge which would permit increased dosage.

Even under these circumstances, the attorney continued, the MD who gets involved in a malpractice suit for prescribing dosage which exceeded the manufacturer's direction will have a difficult time defending himself.

There have been instances where MDs have successfully defended themselves in such cases, but it was necessary for them to produce a considerable amount of scientific data.

The medicolegal expert advised that if a physician feels the recommended dosage could be exceeded, he should write the firm for information.

Pharmaceutical houses keep abreast of all medical literature dealing with their products and usually employ a physician who can give advice.

AMA NEWS, October 19, 1959

Acute Dissecting Aneurysm of the Aorta

Surgical correction of dissecting aneurysm of the aorta is now possible. Exact diagnosis is therefore more important than ever. The histories of 11 patients who underwent surgery have been analyzed to identify (retrospectively) the symptoms and findings most valuable in establishing the diagnosis. The most important was a history of very severe pain which usually radiated to the back and frequently moved from its original location to another area. This was more severe than the pain of myocardial infarction and particularly significant in the absence of electrocardiographic abnormalities. Roentgenograms were of critical importance in 9 of the 11 cases. Thus, in one instance, the aortogram showed a double-barreled lumen. A difference in the peripheral pulses was present in 6 cases. Systolic murmur, abdominal bruit, and an abdominal mass occurred in less than half of the cases, but were helpful diagnostic points when they did occur. Four of the 11 patients survived surgery and did well after operation. Although the mortality in this series was 60 per cent, the risks of allowing acute dissecting aneurysm to go untreated are so great that the authors advise prompt operation as soon as diagnosis is established.

—Julian R. Beckwith, William H. Muller, W. Dean Warren, and J. Edwin Wood, Jr.: A.M.A. Arch. Int. Med. 104:217 (Aug.) 1959.

Robert E. L. Nesbitt, Jr., M.D.

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Prevention of Prematurity and Fetal Anoxia*

In spite of much progress, there is still no reason for smugness in the field of preventing prematurity and fetal anoxia. In this miniature monograph, Professor Nesbitt offers a number of practical pointers.

The incidence of premature births varies widely in the many reports available for study, but a composite rate of 6.1 per cent of 18,895 births in 193 hospitals in five regions in the United States was reported by Bain and her co-workers.[3] The incidence of prematurity is influenced by maternal race, age and parity, socio-economic status, nutrition, general health, plurality of birth and adequacy of prenatal care.[4] Prematurity is associated with more than one-half of all deaths in the perinatal period and constitutes a particularly important underlying factor associated with death of infants during the first one month of life.[7] Of the known causes, anoxia plays the dominant role in the cause of premature fetal death *in utero*. Placental, maternal and labor complications are the most significant sub-groups in this category.[2] The largest "single" entity associated with neonatal death in premature infants is abnormal pulmonary ventilation, often characterized by hyaline-like membranes and atelectasis of the pulmonary tissue. Biologic immaturity of the infant, presence of maternal diabetes and delivery by cesarean section are important predisposing factors. Unfortunately, however, premature birth is unattended by maternal complications in more than 60 per cent of cases. Moreover, nearly one-third of all perinatal deaths in the premature group are unexplainable after meticulous clinical and pathological appraisal. Thus, it is apparent that the problem of premature birth is more specific in nature and lies in the basic mechanisms of the smooth muscle cell and its metabolism, as well as its neurologic and endocrinologic control. But medicine is a pragmatic discipline and it is not always necessary to know the finite causes of death or disease in order to take effective measures to control them.[10] It is appropriate, therefore, to review current methods of preventing premature labor and delivery and of curbing perinatal wastage associated with this important obstetrical complication.

PUBLIC HEALTH ASPECTS

Public health agencies have played a preeminent role in the attack on this aspect of perinatal casualties. Perinatal loss is one of the most sensitive indices of the social and economic level of a community. One of the positive preventive aspects of prematurity as

*Presented at 193rd Annual Meeting of The Medical Society of New Jersey, before the Section on Obstetrics and Gynecology, on April 28, 1959. This work is from the Albany Medical College.

a community problem is the elevation of living standards among the underprivileged. Low standards of obstetrical care, low standards of living, and ignorance go hand-in-hand. Measures directed toward providing adequate facilities, personnel, and lay education have a positive effect on perinatal losses. Better nutrition and housing, good sanitation and adequate financial resources are necessary tools in implementing a successful public health program devoted to a reduction in premature birth rates and to a greater fetal and neo-natal salvage. This is a joint responsibility of several health disciplines including public health, obstetrics, pediatrics, anesthesiology, nursing and hospital administration. The effectiveness of this health program requires a coordinated effort from these individuals and agencies and cooperation on the part of patients who must present themselves for medical care. Thus, in the broadest sense, obstetrical care becomes the responsibility of the entire community and all of its medical workers.

I should like to call attention particularly to the broad professional educational programs intended to reach everyone concerned with maternal and infant care; especially to those associated with hospitals having small maternity and newborn services with inadequate facilities and personnel. It is important to emphasize the value of wider application of what is now known about patient care. Statewide statistics do not make clear the fact that several counties may have figures far in excess of the mean perinatal mortality rate for the state; and if these same counties had been able to achieve the state rate, a great many lives would have been saved, and the rate for the state as a whole would have been substantially reduced. Medical centers must join with other health agencies in providing professional programs of graduate education on a continuing basis for practicing physicians. The conduct of perinatal mortality conferences in individual hospitals, or perhaps even on a community basis, is an important way of fostering interest and concern for this problem of perinatal wastage.

Provisions for an adequate program of lay education is an indispensable part of a successful health campaign against perinatal losses. A major part of this education concerns pre-conceptional care of patients. Certain women have disproportionate perinatal wastage. Premature birth is merely one complication in a broad spectrum of related obstetrical events which may result under other circumstances in abortion, fetal death *in utero,* fetal deformities or problems of the newborn period with immediate and remote sequelae. Restoration of all demonstrable medical, anatomic, psychologic, endocrinologic and other defects to normal, prior to and during pregnancy, will enhance the probability of perinatal salvage. The outlook for patients who have a recurring factor responsible for a high reproductive failure rate, characterized by any of the aforementioned events, may be considerably improved by appropriate therapy to improve the generative tract environment prior to conception. A successful program depends upon an acute awareness on the part of all medical workers interested in maternal and child health that the success depends in large measure upon the patients' general health status when conception occurs. It follows, therefore, that all physicians, regardless of specialty, in treating patients during the pre-conceptional period, play a vital role in ensuring the satisfactory outcome of pregnancy, and that these physicians are dependent upon an effective program of lay education to ensure the recognition and acceptance of this pre-conceptional care by the general population.

MEDICAL AND SURGICAL ASPECTS

THE reduction of perinatal mortality in premature infants primarily involves obstetrical considerations. With few exceptions, the longer the fetus can remain in the uterus the better are its chances of extra-uterine survival.[8] Certain medical advances in the management of specific medical illnesses, such as heart disease, diabetes, hypertensive disease, infectious diseases, tuberculosis, hyperthyroidism and others, have made it possible for many patients to undertake pregnancy and to proceed further beyond the period of fetal viability than formerly without increasing jeop-

ardy to the mother. Careful prenatal supervision of certain medical diseases complicating pregnancy, including several admissions to the hospital during pregnancy for evaluation, rest and control will prevent the onset of premature labor in many cases. The expectant treatment of placenta previa makes it possible with the ready availability of blood banks to carry some patients under close supervision closer to maturity without great risk to the mother. Syphilis, once considered to be a prominent cause of premature birth, is one factor for which prevention can be assured definitely in a very large proportion of cases if the pregnant woman is adequately treated. Close prenatal supervision of obstetrical patients is a pre-requisite to the prevention of the toxemias of pregnancy, and by the same token, the incidence of *abruptio placentae,* which frequently accompanies this disease process, is substantially reduced. Uterine irritability is common in patients with multiple gestation, toxemia, infection and bleeding. In each of these conditions, utero-placental circulation may be impaired. Adequate rest is a vital adjunct in the management of these patients if the incidence of premature labor is to be mitigated. The latent period between premature spontaneous rupture of the membranes and delivery varies considerably and bears a direct relationship to the period of gestation; the earlier in the gestation rupture occurs, the longer the interval is likely to be. If possible, the patient should be kept in the hospital until the drainage of fluid ceases or labor ensues spontaneously; but it is not necessary to induce labor. Chemotherapy should be instituted at the onset of labor, since organisms in the lower genital tract spread upwards at the onset of uterine activity. No orificial examinations should be made until the onset of labor. This regime allows a prolongation of fetal life in many cases without undue hazard from infection.

The newer medical and surgical technics available to the physician make it possible to arrest more tuberculous lesions and salvage more pregnancies than ever before. The interruption of pregnancy in such cases is rarely indicated. This trend away from obstetrical intervention is noted also for other medical and surgical conditions complicating pregnancy. The operation of partial thyroidectomy in adenomatous goitre with hyperthyroidism and the use of propylthiouracil and other antithyroid agents enable the pregnant woman to carry through pregnancy with reasonable expectancy of health and of normal, living offspring. It is possible to carry out other surgical procedures, preferably about the 18th to 20th week of gestation, without jeopardizing the pregnancy. Surgery for removal of ovarian cysts or tumors, and the occasional myomectomy, that is indicated during pregnancy, should be carried out at this stage of pregnancy to minimize abortion or premature labor. Ideally, of course, these surgical procedures should be done preconceptionally in anticipation of a good perinatal outlook in subsequent pregnancies. Certain patients with a history of habitual abortion or recurrent premature labor in association with uterine anomalies, especially when endocrine and other defects have been excluded, can be offered an improved obstetrical prognosis by plastic surgery, particularly correction of a *uterus subseptus* or bicornis. Another small selected group of patients, who have had repeated premature deliveries in association with an incompetent internal cervical os, may benefit from surgical closure of the cervix at a stage of about mid-pregnancy. A strip of synthetic material or fascia is snugly placed submucosally about the circumference of the cervix near the level of the internal os.

ENDOCRINE ASPECTS

A NUMBER of hormones have been used for the prevention of premature birth with varying success. Among these are thyroid hormone, progestational agents, various natural and synthetic estrogens, and, more recently, Relaxin. The female sex hormones have received the widest trial. Many believe, however, that the value of hormone therapy in the prevention of premature birth has not been definitely established, and its use rests on an insecure basis of conflicting reports without a clear demonstration of value. Moreover,

uterine physiologists are not in agreement about the relations between estrogens, progesterone, and uterine activity in the human, although progesterone has an inhibitory effect upon the uterus of the rabbit and other experimental animals.[9] The hormonal interrelationships that may be needed to produce the physiologic effect on the uterus may be a finely adjusted point that alludes available technics of study. Uterine activity starts to increase gradually several days or weeks before labor, both in premature labor and in full-term pregnancy, and is particularly evident in toxic patients, but the precise role of hormonal factors involved in this hyperirritability is unclear. A reduced progesterone-estrogen ratio has been suggested as an important factor in some cases. Nevertheless, the effect of progesterone administered in large doses in diminishing uterine motility has been used to advantage in selected cases in preventing premature labor; and more recently, the use of Relaxin has been recommended as a means of possibly altering or halting uterine contractions in certain cases. In general, however, I have not felt from my own experience that hormones or drugs play any great role in the prevention of premature delivery when used empirically.

The use of hormones in selected cases as substitution therapy for demonstrated deficiencies is on a much firmer basis. The functioning quality of the endometrium and, later, the decidua, may decide the fate of the embryo and fetus by affecting development of the chorion. If the integrity of the trophoblast is good, a large quantity of chorionic gonadotrophin is secreted, stimulating the ovary to maintain an adequate output of progesterone and estrogen which maintain the endometrium and growth of the trophoblast. These metabolic and hormonal processes are essential for proper intrauterine environment and growth of the fetus. Preconceptional workup and treatment, which is then continued during the early months of pregnancy, will do much to assure in selected cases the continued growth of the fetus throughout the remainder of pregnancy. Every effort must be exerted to identify and treat preconceptionally all women who are likely to have disproportionate pregnancy wastage because of some recurring factor.

OBSTETRICAL MANAGEMENT

As a basic principle, it is important to recognize the fact that only a minority of obstetrical patients are free of all conditions or deviations which are known to increase the "basic" perinatal mortality and morbidity rates. Thus, multiple clinical factors must be weighed and summated in establishing criteria for the management of obstetrical patients. This attitude is particularly important in managing premature labor. The emphasis on prevention of premature labor must be augmented by special care of such cases if labor cannot be prevented. Anoxia of the newborn infant in the first hours or days of life may be the result of improper management of labor. This oxygen deficit is especially costly in terms of neonatal outlook. Certain objectives must be kept in mind if the obstetrician is to minimize fetal anoxia.[5] When the fetus is subjected to anoxia from unavoidable maternal complications, avoidance of multiple insults to the fetal respiratory center should be the primary objective. Narcosis of the mother should be avoided in the management of premature labor. Competent and judicious anesthesia must be sought, using analgesia whenever feasible. Trauma must be avoided meticulously. Intracranial hemorrhage may be found in association with anoxia of the fetus irrespective of the method of delivery. Congested cerebral vessels with intimal anoxic injury may be ruptured with very minimal cranial stress. Prolonged cranial pressure from arrested progress in the second stage of labor must be avoided. It has been my policy to deliver immature fetuses spontaneously if possible, or by gentle extraction with forceps if necessary, assisted by a generous episiotomy. Minimal to no analgesia for premature labor and delivery is my general rule. Local or regional anesthesia is used in almost all cases. Oxygen is usually administered to the mother for more than ten minutes prior to delivery of the infant and during early labor if the need arises. High concentrations of oxygen administered to the mother for a period of 10 to 15 minutes will effectively increase the oxygen saturation of cord blood. The umbilical cord is not clamped until pulsations cease, since premature infants

have a tendency to become anemic. Thus, care of the premature infant actually begins prior to delivery while the fetus is still *in utero*. This care begins in a more direct fashion when the infant's face appears over the perineum and becomes accessible for gentle nasal and post-pharyngeal suction. Postural drainage of the upper respiratory tract should be promoted following delivery aided by additional nasopharyngeal suction. Rough handling of the infant should be avoided.

It should be emphasized that problems of fetal immaturity may be created unnecessarily by the obstetrician when he fails to confirm maturity before the elective induction of labor or cesarean section. Where there is a serious doubt about the estimated fetal weight in a patient who is to have a repeat cesarean section, it is often a wise policy to admit the patient to the hospital and await early signs of labor before carrying out the procedure. The problem of selecting a time for early delivery in certain cases of maternal diabetes, mild toxemia, iso-immunization and other conditions is more tedious and requires a nicety of judgment. Certain erythroblastotic infants, delivered at a stage of marked immaturity, are predisposed to a high risk of kernicterus. Moreover, in an attempt to avoid the complication of fetal death *in utero*, early intervention in certain diabetic patients frequently yields a physiologically immature infant who succumbs neonatally. The principal hazards are anoxia, trauma, hypoglycemia, and hyaline-like membrane disease of the infant. Until proper placental function tests are available, the obstetrician will have to rely upon his judgment in avoiding or minimizing these hazards.

PEDIATRIC CARE

THE emphasis here on the obstetrical and preventive factors involved in premature birth should not be taken to mean that good pediatric care will not improve the neonatal salvage. The ultimate prognosis for the infant during the ensuing days, months and years is largely dependent upon the effectiveness of management during the critical several minutes following birth. The significant immediate desiderata are: a clear airway, oxygen, warmth and as little handling as possible.[5] In the presence of anoxia, *apnea neonatorum* will respond only to correction of the anoxia itself. Intra-tracheal aspiration should be reserved for cases in which apnea occurs secondary to obstruction; and if necessary, is best carried out under direct vision with the laryngoscope. The lungs may be expanded by intermittent positive pressure in cases of primary apnea after the possibility of obstruction has been eliminated.[6] Gastric lavage should be carried out following cesarean section and in the infants of diabetic mothers. Anoxic infants should be generally supported by maintaining temperature and humidity. They are in a state of vascular collapse and should be treated as any other patient in shock. Antibiotics may be administered to these infants to minimize the dangers of pneumonia. Following resuscitation the infant should be placed in an incubator with oxygen not to exceed 40 per cent, and the low levels of oxygen concentration assured through the use of an oximeter.

Special comment should be made about the need for expert pediatric management of erythroblastotic infants and for the availability of adequate facilities and personnel to perform an immediate exchange transfusion and to repeat it as necessary. This is particularly important in the management of premature infants who are especially predisposed to the development of kernicterus because of greater permeability of the blood-brain barrier for bilirubin. Jaundice can be controlled and brain damage minimized or prevented by exchange transfusions given early and repeated if necessary.[1] An effort should be exerted to keep the serum bilirubin level below 18 to 20 milligrams per 100 milliliters. Infants who are subjected to intrauterine anoxic injury are particularly susceptible to kernicterus and must be given special consideration with respect to therapy.

The precise environmental requirements for premature infants remain a controversial matter in spite of extensive research. It is true that we should give proper emphasis to temperature, humidity, oxygen and chemotherapy,

particularly in infants with the respiratory distress syndrome, but the factors of environmental control are complex and, perhaps, less significant than we thought a decade ago in reducing neonatal mortality in premature infants.

CONTINUED RESEARCH EFFORT

It is only through the continued acquisition of knowledge can any true millennium be near at hand. Almost 40 per cent of the total combined and maternal mortality in the United States, according to an estimate of Eastman, are due to functional myometrial disorders. Yet, when we look into these problems of uterine dysfunction, we find that we are ignorant of much of the basic patho-physiology involved, although recent physiological studies hold promise. A basic understanding of maternal-fetal oxygen relationships, and the precise effects upon the fetus, both immediate and remote, are quite fragmentary. Broad areas of research must be encouraged at all basic levels of human reproduction and comparative physiology. Application of this new knowledge to the betterment of perinatal welfare will inevitably follow through the coordinated activities of multidisciplinary groups of medical workers concerned with maternal and child health.

THE ALBANY MEDICAL COLLEGE

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Cancer of the Penis

Bernhard* lists prophylactic measures against cancer of penis as: universal circumcision of male infants, immediate treatment of pre-cancerous conditions (balanitis xerotica obliterans, leukoplakia, erythroplasias, ulcerative lesions of undetermined origin). Diagnostic doubts should be resolved by biopsy; early neoplastic lesions treated with partial amputation (1.5 cm. proximal to any palpable or visible lesion) and biopsy of inguinal nodes with lymphadenectomy, if indicated, in stages to prevent circulatory difficulties; close follow-up. Radical amputations in early cases do not prolong survival. Radiation treatment may cause avoidable disabilities: several weeks' pain, penile contractures and resulting functional impotence, urethral strictures. Average age of 23 patients treated was 50, range was 28 to 78.

*C. A. Bernhard (Guatemala City): Rev. Col. med. Guatemala 9:217 (Sept.) 1958.

Allen A. Parry, M.D.

Madison

Management of Alcoholism in a General Hospital*

Alcoholism, says Dr. Parry, is not a psychiatric problem, but a fault in body chemistry. Described is an almost unique general hospital program for the alcoholic—one which any other alert general hospital can follow. Proper nutrition and medication are the keystones of this approach.

The need for more facilities and improved care for alcoholic patients in New Jersey cannot be questioned. Alcoholism is the fourth ranking health problem in the United States. In 1956 there were 232,000 alcoholics in New Jersey; of these 34,000 were women. New Jersey ranks second (behind California) in *per capita* incidence of alcoholism. We are one of the few states in the top ten in which the incidence is increasing rather than decreasing. In general, the care of alcoholics in our state is inadequate, the matter of prevention is ignored, and the follow-up care is absent.

Several considerations led us to undertake the establishment of an Alcoholic Service in Morristown Memorial Hospital. Each of us sees many people who have a problem with alcohol. We may not agree in all instances that alcohol is the primary problem, but the disease is widespread. Doctors, as individuals, cannot do this job alone. Most physicians know very little about the disease. Few of us will devote the time and sympathetic understanding necessary to the task in each individual patient. Many do not even have an accurate knowledge of specific regimes of therapy; for example, what drugs have been most successfully employed, and which are contraindicated in alcoholics.

We have been distressed by the fact that we had not had adequate follow-up care for patients who had been in our hospital with an alcoholic problem. This includes patients in all walks of life, of all social and economic situations, and of all races and creeds. We had had too little to offer these people after discharge from the hospital, and often did not know how to utilize services available elsewhere.

Accordingly, an Alcoholic Service was established in Morristown Memorial Hospital in March 1958. It includes in-patient service and clinic facilities. In-patient care is rendered by the three internists who are members of the Alcoholic Service which is an autonomous service under the Chief of Medicine. Medical members of the Alcoholic Service are also available for consultation to other members of the staff. Hospital patients are admitted on the same basis as medical and surgical patients: emergencies always being admitted, elective admissions as bed space permits. Semi-private and private patients are accepted from any area as space permits. Thus there is no discrimination against these patients as regards admission or treatment. We stress this because many hospitals do not

*From the Alcoholic Service, Morristown Memorial Hospital, Morristown, N. J.

like to accept patients whose primary difficulty is alcoholism. We think this is wrong; not only does alcohol produce pathology, but these patients are as likely as anyone else to have pathology unrelated to their primary disease, and more likely to ignore the early symptoms.

THE out-patient care of patients is accomplished in our Alcoholic Clinic, in which the same internists are assisted by two social workers, two evenings a week. Patients are referred to the Alcoholic Service, both in-patient and out-patient, by physicians, the clergy, legal authorities, social agencies, Alcoholics Anonymous, members of the family, friends, or by the patients themselves. There is an emergency service available on a 24-hour, seven-day week basis. The clinic is open two evenings a week. Clinic fees, worked out by the social workers, are from nothing to $5.00, depending on the patient's ability to pay. The doctors in the Clinic are not paid. If the patients are able to pay, the doctors are, in effect, donating their fees toward the cost of the Service.

Every patient in the Clinic, who has not been in the hospital, has a complete medical work-up. All the facilities of our hospital, including other clinics, are available to us. The patients are seen frequently. Whenever possible, we work closely with Alcoholics Anonymous. Patients who object to A.A. fall into two classes: (1) those who have had contact with A.A. which, for one reason or another, was unsatisfactory, and (2) those who do not know anything about A.A. but resent the idea. Many patients of both types can be successfully introduced or reintroduced to A.A. if the proper approach is used. A.A. succeeds in many times more cases than any other agency.

This is a *medical* disease, not a psychiatric one. A sympathetic, not critical, attitude on the part of the staff is essential. These people are to be helped, not condemned. They have acquired all sorts of personal problems—financial, legal, social, familial, sexual, and so on, as a result of their drinking. I repeat that these are *personal problems, not personality problems*. The alcoholic and the spouse need counselling by physicians and social workers who are aware of the available social and legal agencies that can be employed in aiding them with their problems.

We have acquired certain basic beliefs about alcoholism: (1) We believe it is a medical condition, a disease. We feel that *the ultimate answer to it will be found in analysis and correction of faults in body chemistry*. It bears striking similarities to certain glandular disorders. It needs primarily medical management. We refer not only to the acute episode, which is obviously medical and usually requires hospitalization, but also to the management of the patient who has the chronic disease, even though he may not be drinking, much as diabetes requires constant management. We feel very strongly that *this is not a psychiatric problem* except in rare instances.

(2) There is abundant evidence that the overwhelming majority of alcoholics cannot manage alone. They need help outside their own family and immediate circle of friends, especially their drinking friends. Families need intelligent, sympathetic understanding of the condition, and this usually requires some indoctrination and counselling from informed sources. It is sometimes difficult but always rewarding to establish communication within the family. If the alcoholic can talk freely about his problem it becomes easier for him.

(3) It has been found to be true in private practice and in clinics elsewhere that success in the management of these patients is proportional to the frequency with which they are seen. Members of Alcoholics Anonymous know this better than anyone else.

(4) Most alcoholics, by the time they get to a Service such as ours, desperately want help. They are the loneliest people in the world. There is no more cruel, more wrong, or more stupid statement than that they could stop drinking if they really wanted to. They want to so much that many commit suicide when they cannot. This is true even in people without any problem other than alcohol.

(5) The issue here is not a moral one. It is not wrong or morally reprehensible to drink. Alcoholism as a disease is not a moral question at all; nor is it a question of strength of will. Alcoholics acquire a compulsion which we feel is on a physical, not a moral or emotional basis. Alcoholics Anonymous rightly stresses that the first drink is the only phase in which the drinker has any very real control over the problem.

(6) With help, most alcoholics can recover, in the sense of being kept off alcohol. Others can be helped to the extent that alcohol becomes much less of a problem. Success in this depends to a large extent on the desire of the patient for help. Success is less likely in patients who are forced to seek attention, and who do not really want to stop drinking. However, it is a mistake to assume that, just because the patient has sought medical help under duress, he does not want to stop. Several have done very well after a period of discus-

sing the matter with us and absorbing some of our philosophy and experiences.

(7) The criteria for improvement in this disease must not be the duration of time that the patient has not had a drink; it is rather dependent on what sort of adjustment he had made, whether he is self-supporting, whether he and his family are happy, and whether he is productive in the community. We feel that in the past too much attention has been paid to continuous sobriety.

Clinically, most of the acute cases have an enlarged tender liver which returns to normal during the hospital stay. Some of the long-standing cases have large, hard, nontender livers, often with ascites and occasionally with jaundice. In patients with ascites, hydrochlorothiazide in doses of 50 milligrams twice daily has been effective in establishing and maintaining diuresis. Some of the more severe cases have ascites on the basis of low serum albumin values.

Chemically, the most informative findings are: (1) the serum transaminase, which is nearly always elevated, usually between 80 and 400, reflecting the amount of recent acute liver damage; (2) the cephalin flocculation test, whose degree of positivity reflects the amount of long-standing liver damage; (3) the blood urea nitrogen, which is depressed in all cases with severe liver damage. In severe cases, where jaundice is present, the serum bilirubin level has to be followed. In some of these cases, with or near hepatic coma, it has seemed to us that the administration of steroids in large doses has been lifesaving; in the ordinary acute cases we have not found it necessary to administer steroids.

In our hands, the determination of serum ammonia levels has not been helpful either in prognosis or treatment. Some recent reports suggest that the difference between arterial and venous ammonia might be significant; we have not made such determinations. Fasting blood sugar levels are usually normal; some patients have a flat glucose tolerance curve, and an occasional patient has a curiously inverted curve where the levels from ½ hour to 2 hours are below the fasting level, but values are up to normal by 4 to 6 hours. In these patients, the curves have been restored more nearly to normal levels when normal nutrition has been accomplished. We have encountered no cases of real hyperinsulinism.

THE management of the acutely ill alcoholic is fairly well standardized among physicians accustomed to dealing with the problem. The most important single aspect of medical control is provided, of course, by the adequate use of tranquilizing drugs. All such drugs have been used at different times and places by different groups, and probably all are adequate if given in sufficient dosage for sufficient length of time. Those not accustomed to dealing with the acute alcoholic are apt to give too little and too late, a situation which makes the patient less manageable and more excited, thus putting unnecessary work on the nursing staff.

Our routine in normotensive patients is to give promazine hydrochloride intramuscularly 200 milligrams on admission. This is repeated in two hours and then given every four hours by the clock. In addition, a nightly oral sedative is given. We prefer glutethimide, 1 Gram at bedtime with an extra 0.5 Gram to be given if necessary. Also we always leave an order for sodium amobarbital 0.5 Gram to be given intravenously every six hours for extreme restlessness only. It is seldom that more than one or two doses of the latter is required in any one patient.

With this type of regime, most patients can be aroused for meals, but are drowsy most of the rest of the time. In severe cases intravenous feedings of glucose in saline or water, containing 10 cubic centimeters of adrenal cortical extract and a suitable dose of parenteral vitamins, are given one to three times daily. In these heavily obtunded patients we find that frequent change of body position is required to prevent hypostatic pneumonia.

In addition to the amount of sedation given, the important thing is the duration of such therapy. Complications of alcohol withdrawal are convulsions and/or hallucinations, usually visual or auditory. They occur almost invariably 36 to 72 hours after withdrawal. If the patient is sufficiently obtunded during this period, they do not occur; if they are occur-

ring when the patient is admitted (which means that withdrawal started earlier) the same treatment routine abolishes them. Restraints are not necessary.

After two to four days, depending on (1) the patient's condition, (2) the results of the blood chemistries and (3) the history and duration and amount of alcohol intake, promazine hydrochloride is given only when required, and meprobamate is given in doses of 400 milligrams every four hours when the patient is awake.

In hypertensive patients, reserpine 2.5 milligrams intramuscularly is substituted for the promazine hydrochloride at the same time intervals. This has proved very satisfactory and we have encountered no cases of hypotension as a result of this medication. Large doses of parenteral or oral vitamin preparations are given.

DURATION of hospitalization varies widely. In our hospital the average is seven or eight days. The patient must stay until his symptoms have subsided and blood chemistries turned to normal. And it is even more important that he stay until he can intelligently discuss his problem, agree to the acceptance of subsequent help in the Clinic (and, if possible, in Alcoholics Anonymous) and understand something of our philosophy of the disease.

Diet also needs attention. These people should be on a high protein diet with carbohydrates reserved for the periods when they feel shaky, nervous, perspire freely, and would usually feel that they needed a drink.

Oral vitamins in large doses are employed. The most thorough and complete work on the subject of nutritional therapy is *Alcoholism: The Nutritional Approach* by Roger J. Williams (University of Texas Press 1959). Everyone who treats alcoholics on an outpatient basis is urged to use this book as a basic reference.

Other medications are usually necessary during the few weeks or even months following the acute episode. Meprobamate has been used up to 400 milligrams every four hours during the day, gradually decreasing the frequency and size of the dose. Sometimes a dose of one of these drugs, taken with a quickly available source of sugar, will enable the patient to get by a trying period without taking a drink. Since a great many alcoholics have insomnia after drying out, some night-time medication may be necessary. We have found glutethimide 0.5 to 1 Gram, most helpful in this regard, but this should also be decreased gradually and eliminated as soon as is consistent with the patient's well-being. The occasional patient who does not tolerate this medication may be helped by any of the ordinarily prescribed night-time sedatives—and we do not feel that any is contra-indicated as long as alcohol is not being ingested.

WE HAVE had more than 150 patients admitted to the hospital and have seen more than 200 patients in the Clinic in a period of sixteen months. In the hospitalized cases, the ratio of women to men is four to nine. Best results are in people who are admitted to the hospital and subsequently seen frequently in the Clinic. This immediately suggests that one of the limiting factors in our effectiveness is geographical because it is manifestly impossible for some who come from considerable distances to attend our Clinic regularly. It has, therefore, been our intent in recent months to limit admissions (except in drastic emergencies) to an area from which we could reasonably expect subsequent Clinic attendance. It may be that some people cared for in the hospital and not subsequently seen in the Clinic are doing well, and, in fact, we know from follow-up letters that in some instances this is so; however, follow-up in these people is inadequate and we are dissatisfied with any program in which we cannot determine ultimate results.

Not enough general hospitals in the state admit alcoholics and not enough have facilities for women with this disease. The prejudice against admission dates from the time when methods of care were more limited and these patients were more of a burden on the nursing service. With present adequate meth-

ods of treatment such a viewpoint is archaic. It is especially to be deplored that hospitals which house state-sponsored clinics do not admit patients from these clinics to the hospitals.

We have been gratified by our results and by the fact that this is a most rewarding type of work. We urge that general hospitals throughout the state establish Alcoholic Services according to their community needs, and that they cooperate with and seek the cooperation of members of Alcoholics Anonymous. A.A. has long carried the bulk of this load without help from the medical profession. If we acknowledge that alcoholism is a disease, it is our moral duty as a profession to care for it. Such care in a general hospital has been demonstrated to be feasible and not too difficult. The care to which these sick people are entitled demands that hospitals admit them and that physicians take proper care of them; and it necessarily implies closer cooperation between the medical profession and A.A. than has existed in the past.

SUMMARY

(1) There is a great need for facilities for the care of alcoholics in New Jersey.

(2) At present the need for in-patient care is greater for women than for men, but both are lacking.

(3) This care can be rendered in the general hospitals throughout the state—and in fact there are many philosophical reasons why they should undertake it, rather than allow special or psychiatric facilities to do the job.

(4) Care of these patients by well instructed medical and nursing personnel does not impose a great burden on those personnel involved. Such instruction is available in our hospital and elsewhere.

(5) Every general hospital in New Jersey should establish an Alcoholic Service, consisting of in-patient and out-patient facilities, to care for these people who are currently neglected by the medical profession. Out-patient clinics without in-patient facilities are essentially useless.

(6) Every such facility should work as closely as possible with members of Alcoholics Anonymous to insure adequate subsequent care and follow-up. Alcoholics Anonymous has been doing this job without the medical profession for many years to our shame.

(7) The outline of such a working program, as has been demonstrated in our hospital, presented in this present paper has been shown to be feasible and practical. We feel that other general hospitals in our state which are ignoring this problem are not fulfilling their entire responsibility to their communities.

54 Green Avenue

Control of Alcoholism

The ability of prochlorperazine to induce relaxation without mental clouding and to control withdrawal symptoms was demonstrated in the majority of 45 alcoholics.* Initial treatment consisted of intramuscular injection of prochlorperazine in doses of 20 to 50 milligrams. After control was established all patients were maintained on oral dosage of 30 milligrams prochlorperazine twice daily. Duration of therapy was two to seven days. Concomitant treatment included use of vitamins and restoration of fluid and electrolyte balance. Side effects were not observed in alcoholics treated with prochlorperazine.

*Thimann, J. and Gauthier, J.: New England Journal of Medicine, 260:915 (Sept.) 1959.

Thomas K. Rathmell, M.D.

Trenton

The Value of Twins to the Paternity Referee*

It used to be said that it was a wise child who knows its father. As Dr. Rathmell says, the reluctant father is entitled to a day in the laboratory before his day in court.

"Maternity is a matter of fact; paternity is a matter of opinion." This statement by a nineteenth century writer cannot be considered entirely true today. The development and utilization of blood tests by trained clinical pathologists have made the question of paternity susceptible to scientific study. The first English paternity statute was enacted in 1576. This is the parent of all Anglo-American legislation designed to secure support for children born out-of wedlock. Men have been wrestling with the legal aspect of paternity for some 380 years.[1]

Some jurists still adhere to the concept that intercourse at the material time of conception renders a man liable for the support of the child. Fortunately, this attitude does not prevail in our locality. We have attempted to referee twenty-seven cases during the past ten years. Immunologic exclusion for the accused father has been established in five cases (18.5 per cent). Certain procedures have been formulated which may be valid and noteworthy.

Cases were referred by either a Welfare Officer, the Court, or through request of the defendant's legal counsel. In each instance, we have tried to enlighten all parties to the contest as to the nature of our tests and to assure them of our strict neutrality. Previous pertinent history has been noted, including the educational level of contestants, physical characteristics of an identifying nature, the age, place of residence and occupation. These preliminary discussions give an indication of the reliability of the contestant's answers. Blood tests have demonstrated that some women tell untruths about the paternity of their children.

It is essential to obtain written consent for the collection of a sample of blood and that of the offspring for the purpose of biologic study to determine, if possible, the paternity of the infant. The consent must be signed by all parties to the contest. These become a permanent record of the referee's file. Information about the time of sexual relations, the use of contraceptives and time of delivery is sought from both contestants. Our experience has been that either one or both parties to the contest never heard of Diogenes. Nevertheless, all data become part of the referee's records.

I personally collect all blood specimens, label them in the presence of the contestant and make them identify their names on the labeled specimen in front of witnesses. I personally follow each specimen through the battery of immunologic reactions. I read each test. They are also read by a medical technologist (ASCP), who has been certified as a Blood Bank Technician by the American Society of Clinical Pathologists and has over twenty years' experience in the field. Even then, all tests are done in duplicate and al-

*From the Department of Pathology, Mercer Hospital, Trenton, New Jersey.

1. Gradwohl, R. B. H.: Legal Medicine, C. V. Mosby Co., St. Louis, 1954.

ways repeated if an exclusion is encountered. Controls are run on all tests.

I have made it a practice to do serologic reactions on each of the adult contestants. In two instances we uncovered previously unrecognized positive serology.

IN OBTAINING blood from infants, we are sometimes successful in securing blood from the veins of the forearm, the femoral vein, or the external jugular, utilizing a twenty-five gauge needle and a two cubic centimeter syringe. However, as a general rule, when the infant is three months of age or under, we have found it preferable to have our antisera in 7 millimeter tubes and collect blood in successive drops after cross-lancing either the large toe, or the infant's heel. In addition to this, one must also obtain at least a 40 per cent suspension of red cells in isotonic saline to facilitate testing for the M, N, and CDE factors.

Blood tests can detect known paternity in about 55 per cent of false claims. One-third of the paternity cases brought to the Court of Special Sessions in New York City were false charges. One must always be aware of the accused "He" being medically a "She," or the accused "He" having defective or absent sperm and therefore impotent.

Human twin studies have been extensive and blood groups are of undoubted importance here. Twins are dizygous if they are of different sexes; or if their blood groups are different; but if their blood groups are the same, they may be either dizygous or monozygous.

Our studies of a recent paternity contest involving the birth of female twins produced the immunologic facts below.

Review of these findings shows that had it not been for the twin birth, we would have been unable to spot the father as an A_1 CDe/ce and thereby exclude our accused male (A_2 cDe/ce) of paternity.

The question of superfetation was considered, but not given any weight because of its rarity. Had this happened, the patient would have been pregnant with one fetus and subsequently would have ovulated. Then fertilization would have again occurred. Such a sequence of events would involve a time lapse in the birth of the fetuses. As this was not the case, this concept was abandoned. While some French authors say that superfetation has been conclusively demonstrated, others[2] consider that it is as yet unproved in the human. If different males had participated in such a fertilization process, the progeny would then be half-sisters.

Superfecundation was also considered. By this we understand the fertilization of two ova within a short period of one another, but not at the same coitus. However, the difficulty in proving such a situation is obvious.

While some importance was attached to the A_2 A_1 findings, exceptions have been noted. We therefore did not focus too much attention on this as a factor of exclusion, though it does carry some weight. We prefer to stand on two feet in all exclusion cases and therefore focused on the presence of the large C in one twin. This factor was demonstrated to be absent from the blood of both supposed parents, especially the accused father. It was reasoned, therefore, that the father of these twins would have to be an individual whose blood group was A_1 and whose rh' C factor was positive.

Most blood groups are inherited as dominant characters; but in the Lewis group, the mating of Le(a-) x Le(a-) was found to give Le(a+) children. (Anderson, 1948). "It is considered that this group is inherited as a recessive character."[3] This is offered as a point

2. Eastman, N. J.: Williams' Obstetrics. Appleton-Century-Crofts, Inc., N. Y., 11th Edition, 1956.

	Type	C rh'	D Rh⁰	E rh''	c hr'	e hr''	M	N	Kell	Cellano	S	Duffy	Serology
Accused Father(1)	A_2	0	+	0	+	+	+	+	0	+	0	0	Neg.
Mother(2)	0	0	+	0	+	+	+	+	0	+	0	+	Neg.
1st. Twin(3)	0	0	+	0	+	+	+	+	0	+	0	0	
2nd. Twin(4)	A_1	+	+	0	+	+	+	+	0	+	0	+	

of information, despite the absence of Lewis antisera from our panel.

Most workers feel that in paternity contests, about 35 per cent of the falsely accused males may be excluded; obviously, our cases of exclusion have only been about half this proportion. We attribute this to the relatively small series of cases that have been studied. In all of our cases, exclusion has been based on two immunologic factors, rather than a single immunologic factor.

All paternity contestants should have a day in the clinical pathologist's laboratory before they spend a day in court. By such activity, the jurist will be in a better position to adjudicate the paternity contest. In this instance, the birth of twins proved a blessing in disguise for the accused male.

3. Stratton, F. and Renton, P. H.: Practical Blood Grouping. Charles Thomas, Springfield, Illinois, 1958.

SUMMARY

1. A paternity contest involving the birth of twins of the female sex is presented and discussed.

2. Exclusion of the accused father was possible on the basis of two immunologic factors obtained on one twin and absent from the blood of both the mother and accused father.

3. All paternity contestants should visit a clinical pathologist before being subjected to a day in court.

446 Bellevue Avenue

ACKNOWLEDGMENT

The author wishes to acknowledge the technical assistance of Miss Esther Bowser, M.T. (ASCP), who assisted in the performance of the immunologic reactions.

Getting Emotional About X-ray Hazards

Among some of us, reaction to changes in permissible radiation levels is provoking an emotional response not found in other potentially hazardous areas. This is said in an editorial ("Radiation Hazard: Fact or Fancy") in the April 1959 issue of *Radiology*. Dr. Thomas, the editorialist, goes on to say:

"Some bacteria in milk and water are accepted, and in these instances reference to a maximum permissible level has been used. Acceptance of a maximum permissible level of irradiation, on the other hand, has been fraught with an emotional response not only by the public but by men of science.

"Outbursts in the press based on emotion rather than considered judgment are excited by reductions in the maximum permissible level of irradiation. The radiologist takes the brunt of these outbursts, especially when brother scientists extrapolate their findings on insects to man. Extrapolation of findings in animal experiments, based on controlled complete numbers, to incomplete human eccentricities of physiology and social habits, give rise to philosophic interpretations, not facts.

"The pendulum is swinging to the side of rationality as the potential good is placed higher in relation to the potential harm, bringing the emphasis into the proper light of the positive rather than the negative aspects of the meaning of the word 'hazard.' This does not mean that the present day users of radiation can relax their attempts to reduce their doses. But the doctor should keep fanciful interpretations at an irreducible minimum."

M. W. Flothow, Jr., M.D.
R. J. Rushmore, M.D.
R. C. Maronpot, M.D.
Albert Abraham, M.D.
Morristown

Ephedrine and Antihistamine Combined Treatment in Allergies

An ephedrine-antihistamine combination was found to give good results in 80 per cent of the patients treated for asthma, allergies, emphysema, and related conditions. There were no serious side-effects and the anticipated sedative effect of antihistaminics was not noted.

Ephedrine for many years was the mainstay of therapy in allergic diseases. During the past few years, however, it has been replaced to a great extent by antihistamines, many of which have undesirable sedative effects.

The following data contains clinical impressions on the use of Ephoxamine®,* a combination of 25 milligrams of ephedrine and 25 milligrams of the antihistamine Phenyltoloxamine®. This combination was formulated with the expectation of eliminating the unpleasant side-effects of each, while retaining the therapeutic benefits of both.

One hundred private patients from the practices of the four authors comprise the series.

Conditions treated were: asthma, intrinsic and extrinsic, 28; acute allergic rhinitis and sinusitis, 20; chronic sinusitis, 32; upper respiratory tract infection, 7; bronchitis, pulmonary fibroses, and emphysema, 12; and pityriasis rosea, 1.

The usual dose was one tablet every four to six hours. Duration of treatment varied from a few days to eight weeks, according to whether the manifestations were acute or chronic. At times the Ephoxamine® was coupled with other therapy, particularly in some instances of upper respiratory infections which required the use of antibiotics.

RESULTS

Of the 28 asthmatics treated the age span covered the years from one to eighty, 24 were adults and 4 children.

	Good	Fair	Poor
Adults	18	3	3
Children	1	2	1

Of the adults with poor results, one complained of insomnia and one discontinued treatment because of the development of a transient anesthesia of the tongue.

Eighteen adults and two children with acute allergic *rhinitis* and/or sinusitis were treated with the following results.

	Good	Fair	Poor
Adults	14	1	3
Children	0	1	1

*Ephoxamine®: Spencer Laboratories, Inc., Morristown, N. J.

Of the 32 patients with chronic sinusitis, 28 were adults, 4 were children.

	Good	Fair	Poor
Adults	27	1	0
Children	2	0	2

Both of the children classed as having poor results developed tachycardia with treatment. We believe the dosage to have been too great in these instances.

Four of the seven patients with acute upper respiratory infections were children. No tachycardia developed within this group.

	Good	Fair	Poor
Adults	3	0	0
Children	4	0	0

All of the twelve patients with bronchitis, pulmonary fibrosis, and emphysema were adults.

	Good	Fair	Poor
Adults	10	1	1
Children	0	0	0

One 39-year old female with extensive pityriasis rosea was treated with Ephoxamine® for the relief of her pruritis. The results were good.

In some instances patients who had failed to respond to Ephoxamine® had similarly failed with other antihistamines. In a few, results were poor because of diminished tolerance to the dose, and perhaps (in the case of the children) the dose administered should have been half a tablet.

Although there were several complications, notably tachycardia, particularly in children, none were serious. This is not surprising considering the known safety of the individual components.

SUMMARY

One hundred patients with a variety of disorders ordinarily treated with ephedrine or antihistamines were treated with a combination of both, Ephoxamine®.

Eighty patients experienced good results, nine fair, and eleven poor.

The complications were few and primarily tachycardiac in nature. Depression and sedation were not encountered.

36 Elm Street (Dr. Flothow)

Mountain Vacation Not Always Restful

Writing in the *Munchener Medizinische Wochenschrift*, October 26, 1959, Halluber points out that a journey to the mountains causes changes in the circulation. In the first few hours there is a slowing of the pulse, a lower blood pressure and a feeling of tiredness. This may be accompanied by vomiting and collapse, which are treated by keeping the patient at rest lying flat, giving him oxygen.

After several hours the second phase begins, with quickening of the pulse and a rise in blood pressure and cardiac output. The breathing gets deeper, CO_2 pressure in the lung falls, the circulating blood volume and the red-cell count increase, and the blood adrenaline level rises. This phase lasts for two to five days, depending partly on the height.

During this period, mountain sickness may occur with restlessness, palpitations, anxiety, headache, dizziness and vomiting. Acetylsalicylic acid and phenacetin are useful in both the treatment and the prevention of these symptoms.

Over a height of 9000 feet, pulmonary edema is sometimes troublesome on the first three nights, coming early in those submitted to excessive strain. Such cases must be returned to low levels as soon as possible and given oxygen.

People with hypertension may go to the mountains, if they do not overstrain themselves. But patients with coronary sclerosis should be persuaded to rest, not only for the first few days but during their whole stay.

Samuel M. Gilbert, M.D.

Newark

Diagnostic Approach to the Diarrhea Problem*

Dr. Gilbert here gives us a simple, practical schema for the differential diagnosis of diarrhea.

In a case of diarrhea, the correct diagnosis depends on determining the specific cause and the exact nature of the ailment. This begins with the history as given by the patient. The acute diarrheas, of a few days' to a week's duration, are generally of toxic, dietary, or infectious origin. They are usually easily controlled by simple light diet, plus either removal of the toxic agent or simple medication.

It is the chronic diarrhea of weeks' to months' duration that are of serious import to the patient. The development of chronic diarrhea in several members of a household or community suggests an infectious cause, such as dysentery or amebic colitis. In patients who give an allergic background history, food sensitivity must be considered. Usually these patients have intermittent rather than daily attacks, unless a common food like milk is the cause, and is ingested daily. Cold milk, in my experience, is a common cause of diarrhea. Seafood, mushrooms, or any other food may be a factor. Drugs, especially antibiotics or laxatives, should be inquired about. The *commonest type of chronic diarrhea is the "emotional diarrhea" of spastic or irritable colon.* Onset of diarrhea with emotional storms or anxiety is common. The diarrhea may be violent, but usually is not associated with the passage of blood. In certain cases of so-called "mucous colitis," large amounts of mucus may be noted in the stool. This is a form of irritable colon although, in some cases, allergy may also be a factor. In many cases of spastic or sensitive colon the patient will volunteer the information that since childhood any emotional conflict was followed by an attack of diarrhea; and, as time went on, the attacks came closer together and were of longer duration.

If the diarrhea alternates with constipation, especially in a patient over 40, one must suspect carcinoma of the colon. If the patient gives a history of severe cramps, the origin of the diarrhea is most likely the colon itself. Then we must look for ulcerative colitis, diverticulosis and diverticulitis, carcinoma, and the colonic neuroses. Functional diarrhea, however, is seldom associated with severe cramps. Bloody diarrhea is due usually to carcinoma or ulcerative colitis, less likely to bacillary dysentery in this locale. The association of diarrhea with rectal tenesmus suggests implication of the lower portion of the sigmoid colon and rectum. Diarrhea associated with abdominal distention requires consideration of partial intestinal obstruction. Distention of the abdomen almost invariably accompanies chronic idiopathic steatorrhea, megacolon, and diarrhea secondary to nutritional deficiency. A history of previous surgery may give the clue to a gastric-colic or gastro-jejunal fistula in the occasional case.

*Read before the Section on Gastroenterology and Proctology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 29, 1959.

PHYSICAL EXAMINATION

THE general appearance of the patient may be a clue as to diagnosis. Evidence of chronic weight loss or excessive pallor or temperature is important. High temperature suggests ulcerative colitis, regional enteritis or diverticulitis coli. Weight loss is also present in these conditions but not usually in early carcinoma of the bowel. A palpable mass in the left lower quadrant of the abdomen suggests carcinoma or diverticulitis; in the right abdomen, neoplasm or regional enteritis.

A rectal and procto-sigmoidoscopic examination is indispensable. The typical picture of non-specific ulcerative colitis is seen with its congestion, pinpoint ulcerations, and active bleeding as the instrument is introduced. The examiner will note a bloody exudate in the rectum. The sigmoidoscopic examination will diagnose 95 per cent of cases of ulcerative colitis since less than 5 per cent begin in a portion of the bowel not reached by this instrument. Neoplasm of the bowel (especially carcinoma) is best diagnosed by this examination since 75 per cent of carcinomas of the bowel are found in the distal 25 centimeters of the bowel. Amebic colitis is usually associated with characteristic ulcers in the rectum and lower sigmoid colon, and the trophozoites can be demonstrated in the mucoid pus removed from the ulcers through this instrument. In some cases of mucous colitis the glistening mucous membrane can be visualized, with excessive mucus covering the mucosa. A normal sigmoidoscopic examination will help establish the functional diagnosis of spastic or irritable colon. The latter diagnosis can be made only if all organic pathology has been ruled out by a complete examination.

STOOL EXAMINATION

A STUDY of the stool is essential in every case of diarrhea. The gross appearance of the stool, the presence or absence of gross or occult blood, the finding of ova or parasites, all are important. Gross blood and pus in a patient in this climate first suggest ulcerative colitis. Chronic bacillary dysentery is a rare cause in this area. The large pultaceous, pale or greyish stool is usually the result of steatorrhea. Excessive fat in the feces is always suggested by its "greasy" appearance. The passage of large, greyish, or greenish, semi-liquid stools containing gas bubbles and a pungent, penetrating odor, and lacking the normal fecal odor, suggests nutritional deficiencies, sprue, or fungus infections (monilia-like organisms).

Other laboratory procedures are also indicated. The usual blood count, hematocrit, and indicated chemical analyses should be done. A gastric analysis is needed if gastric achylia is suspected although diarrhea is present in only 10 per cent of these patients. A basal metabolism, protein-bound-iodine, and radioactive iodine uptake should be done if hyperthyroidism is suspected.

Roentgen examination is necessary. A flat plate of the abdomen will show the gas shadows of distended bowel. The small intestinal pattern will be visualized after an oral barium meal, and the findings of regional enteritis, or nutritional deficiencies noted. Any obstructive lesion of the bowel, polypi, ulcerative colitis, diverticulosis and diverticulitis, will be demonstrated. A barium enema is more effective for study of the large bowel, and will visualize the severe spasm of the spastic colon. It is often possible to palpate the tender colon during fluoroscopy when the patient winces with spasm. This is significant if the patient notes the similarity of the cramps which occur during the roentgen examination and the cramps associated with the diarrhea. It is important to give the barium enema slowly to these sensitive patients since incomplete filling of the bowel due to severe spasm may simulate a filling defect. The paper to follow on the roentgen examinations will give more details of the roentgen appearances of the organic lesions.

DIFFERENTIAL DIAGNOSIS

THE commonest cause of chronic diarrhea in this locality is the spastic, sensitive colon. The next two in order of frequency, but con-

stituting less than 20 per cent of the cases, are ulcerative colitis and carcinoma. The diagnosis of spastic colon is made only by exclusion, in other words, after all organic causes are eliminated by a thorough study of the case. The diagnosis of ulcerative colitis is firmly established by the sigmoidoscopic examination, barium enema study, and the presence of a bloody diarrhea. Carcinoma is discovered by sigmoidoscopic and roentgen studies. Diverticulitis and regional enteritis are diagnosed by roentgen studies with barium. The less common causes of diarrhea include amebic colitis, allergy, nutritional deficiency states, defects in intestinal absorption, toxic goiter, and drugs. Complete examinations as outlined above will differentiate these more unusual causes of chronic diarrhea.

144 Clinton Avenue

Tuberculosis and Influenza

The relationship between tuberculosis and influenza was studied in 43 patients with tuberculous pulmonary lesions, who contracted Asian influenza in 1957. In most patients *the influenza reactivated the apparently inactive tuberculous lesions*; relapses occurred in some who had been dismissed from the hospital for a long time because they had clinically recovered or because their condition was stationary. None of these at the moment of contracting influenza was taking tuberculostatic drugs. *Influenza had no effect on the condition of hospitalized patients with active pulmonary tuberculosis* who were being treated with antibiotics; they were deriving benefit from the treatment and showed no resistance to the drugs. Influenza caused death in most chronic tuberculous patients who showed resistance to all antibiotics. The authors believe that treatment with isoniazid should be continued periodically, until there is complete recovery in patients who have recovered only clinically or whose condition is stationary. Treatment with isoniazid is necessary in case these patients should contract virus infections.

Abstracted from a paper by N. Montanini, G. Pallotta and G. De Ritis. Ann. Ist. Carlo Forlanini 18:370 (no. 4) 1958 (Rome).

Myths of Pregnancy

Writing in the August 1959 *Today's Health*, Joan Pollack collects a choice list of widely-held myths concerning pregnancy. Many women are ashamed to confess to their doctors that they entertain these ideas. But knowing these myths may help the obstetrician understand his patient. Here are some of the most firmly believed-in ideas:

—It is safer to be born in the seventh month than the eighth month. This stems from an ancient belief that a baby tried to get out during the seventh month and if it was strong it succeeded. If it failed and tried again the next month, it would be so tired it would die of exhaustion.

—It is lucky for a baby to be born with a caul. The Roman mid-wives sold cauls for good luck to sailors and travelers.

—Baby's head sinks to the pelvis at the dark of the moon; change of moon starts labor; girls make harder labor than boys; each person the mother talks to after labor starts prolongs the pains; if a woman has a large mouth, labor will be easy; mothers must not breathe deeply during labor since it holds the baby back.

—If you want a boy, eat peanuts; for a girl, eat sweets.

—If you have heartburn, the baby will have lots of hair.

—If you eat ice cream, the boy inside of you will catch cold.

Reuben Yontef, M.D

Bayonne

Treatment of Dermatomycoses with Griseofulvin

Trichophyton and Microsporum infections can be stubborn. We welcome, therefore, the report of Dr. Yontef about the effectiveness of griseofulvin in treating these disorders.

In 1939 Oxford and colleagues[1] isolated griseofulvin, a fermentation product of penicillium, which was subsequently used to eradicate fungi in plants. The therapeutic possibilities of this agent were understood when Gentles and colleagues[2,3] and Martin[4] reported cures of induced ringworm in guinea pigs following oral administration. Griseofulvin was first used in man by Riehl,[5] who treated 15 patients with resistant dermatomycoses and reported strikingly rapid relief in all. Since then several investigators[6-11] have administered griseofulvin orally to patients with tinea of the scalp, skin, or nails caused by Microsporum audouini, M. canis, M. gypseum, Trichophyton rubrum, T. mentagrophytes, or T. tonsurans. Since previously these infections were notoriously difficult to eradicate, considerable interest was aroused by the enthusiastic reports of cures with griseofulvin.

METHOD

Griseofulvin* was used in 15 patients with proved superficial fungus infections (Table 1). These patients had highly resistant dermatomycoses which had persisted for many years and were not benefited by other therapy. Microscopic examination of scrapings, cultures, and examination of hair under Wood's light were used to establish the fungus nature of the infection and to identify the organism. We also treated one patient with a dermatosis which clinically resembled a superficial dermatophytosis.

*We used the griseofulvin tradenamed by Schering as Fulvicin®. It was supplied for clinical trial by G. Kenneth Hawkins, M.D., of the Division of Clinical Research, Schering Corporation, Bloomfield, New Jersey.

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GRISEOFULVIN IN 16 PATIENTS

Diagnosis	Infecting Organism	Number of Patients	Duration of Infection	Duration of Therapy
Tinea capitis	M. audouini	2 male children	1½-3 years	5-10 weeks
Tinea corporis with onychomycosis	T. rubrum	6 adult males; 1 adult female	1-20 years	2-18 weeks
Dermatophytosis with onychomycosis	T. mentagrophytes	5 adult males	2 weeks-10 years	2-16 weeks
Dermatophytosis with onychomycosis	M. gypseum	1 adult male	11 years	8 weeks
Dermatosis mimicking dermatophytosis	Unidentified	1 adult female	10 years	3 weeks

The usual dosage was 250 milligrams four times daily although occasionally higher or lower doses were used if indicated by the early response. We used zinc chlorundesal in the two patients with tinea capitis and Whitfield's ointment or triacetin locally in four patients with tinea corporis. Blood counts and urinalyses were performed before, during and after the period of griseofulvin administration.

RESULTS

Tinea capitis caused by M. audouini: Within one week pruritus diminished markedly and lesions began to clear. A decrease in fluorescence was evident by the second week and by the fourth week it had disappeared entirely in one patient and was only minimally present in the second. Laboratory evidence of cure (negative cultures and total absence of fluorescence) occurred during the fifth or sixth week.

Tinea corporis and dermatophytosis caused by T. rubrum or T. mentagrophytes: Pruritus was eliminated or substantially reduced during the first or second week. The glabrous skin lesions were markedly involuted by the third week of therapy and there was clinical and laboratory evidence of cure by the fourth week.

Onychomycosis caused by T. rubrum or T. mentagrophytes: Some improvement in the nails usually could be observed by the third week of therapy although significant benefit, including regrowth of normal nail, usually required at least eight weeks. Patients with onychomycosis are still under therapy; the length of time required for complete cure remains to be determined.

Dermatophytosis caused by M. gypseum: This patient was treated intermittently and therefore results are difficult to evaluate. Itching decreased rapidly and scaling diminished after a short course of therapy. When administration was temporarily discontinued the scaling resumed, to be fully controlled later when griseofulvin was readministered. There has been progressive improvement of the involved nail.

Dermatosis mimicking dermatophytosis: This patient presented the clinical appearance of Trichophyton infection although laboratory results were equivocal. There was no response to griseofulvin and it was concluded that the patient had a disturbance of the sweat glands which mimicked a fungus infection. The trial with griseofulvin was useful for establishing a differential diagnosis.

Side effects: The results of urinalyses and blood counts remained unaffected by griseofulvin therapy. Clinical side effects, possibly due to the medication, were observed in four patients. A male, nine years old, developed painful erythematous papules on the scalp at the site of infection, which cleared rapidly with hot, wet dressings. A female, 18-years old, had a transient sweat-gland-retention syndrome during therapy but this disappeared without reduction of griseofulvin dosage. A male, 46-years old, complained of radiating pain in the chest which persisted despite with-

drawal of therapy and was unchanged when griseofulvin administration was resumed. The results of thoracic and gastroenterologic examination were negative. A female, 40-years old, experienced gastric distress and nausea soon after therapy was begun. This disappeared when therapy was discontinued but returned, in a milder form, when administration was resumed concurrently with antacids.

COMMENT

Our results confirm those obtained by other investigators. The 31 patients treated by Blank and Roth[6] and the nine treated by Williams and colleagues[7] responded rapidly to griseofulvin therapy. Robinson and colleagues[8] used griseofulvin in 117 patients with tinea of the scalp, skin, and nails; tinea capitis was cured in five to seven weeks, tinea crursis or pedis was cured in four to nine weeks, and onychomycosis was significantly improved in eight weeks. Similar results occurred in the 36 patients reported by Reiss[9] and in the 17 patients reported by Goldfarb and Rosenthal.[10]

Griseofulvin in therapeutic dosage appears to be nontoxic. Analyses of blood and urine were performed by most investigators before, during, and after therapy and it was reported that no significant changes occurred.[5,8,9,10] Mild clinical side effects, chiefly headache or gastrointestinal distress, occurred in a small percentage of patients but these symptoms disappeared after the first few days of therapy.[6,8,9,10]

Goldman and colleagues[11] investigated the factors of resistance and relapse among their 46 patients, all of whom were relieved of dermatomycoses by griseofulvin, and found that true resistance was never encountered although some patients responded slowly. Relapse apparently occurred in two patients with tinea of the smooth skin.

CONCLUSION

Griseofulvin, administered orally in doses of one to two grams daily, rapidly relieves Trichophyton and Microsporum infections of the hair, skin, and nails. Microsporum infections of the glabrous skin are most amenable to therapy while intertriginous dermatophytoses are more resistant and tend to recur because of re-exposure to the source of infection.

Onychomycosis requires relatively prolonged therapy. When the nails are involved, treatment should include local fungicidal measures and mechanical removal of debris. As improvement becomes apparent, appropriate measures to prevent reinfection are necessary.

SUMMARY

Oral griseofulvin (Fulvicin®), 250 to 500 milligrams four times daily, was used in two children and 14 adults with tinea of the scalp, skin, or nails. In tinea capitis and corporis and dermatophytosis there was marked subjective improvement during the first or second week of therapy and laboratory evidence of cure by the fourth or fifth week. Response was slower when the nails were involved; at least eight weeks of administration were required for significant improvement. There were no failures except in the one patient whose condition proved to be nonfungal in origin. Griseofulvin appears to be nontoxic and the few clinical side effects were transient.

851 Avenue C

Paul de R. Kolisch, M.D.

Phillipsburg

Rupture of the Stomach in the Newborn

Report of a Case

In all the world literature, only 55 cases of rupture of the stomach have been reported in newborns. Dr. Kolisch adds a 56th case, offers a tightly reasoned theory of etiology and suggests some prognostic criteria.

Vargas and associates [1] in 1955, collected 55 cases of rupture of the stomach in the newborn. This included some from the hospital with which they were associated. Herbut [2] had reviewed 15 cases in 1943 and added one of his own. Review of the literature since 1955 reveals no further report on rupture of the stomach in the newborn. Thus, this is only the 56th case of rupture of the stomach in a newborn infant ever to be reported.

The condition has been known for more than a century. Siebold (as cited by Vargas,[1] *et al.*) first reported it in 1825. According to Pendergass and Booth,[3] Theile reported 248 cases of ulcer in childhood in 1919; very few of these, however, were in the neonatal period.

CASE REPORT

A 30-year old woman was admitted to the Warren Hospital on September 25, 1953, following spontaneous rupture of the membranes and onset of labor. Expected date of confinement was October 17, 1953. Gestation had not been noteworthy. The history was not unusual, save for a spontaneous abortion at 3 months in 1950. The maternal postpartum course was not remarkable.

The infant was the second-born of male twins, with a birth weight of 3716 Grams, delivered by breech extraction September 25, 1953. (The first-born had an uneventful neonatal course.) Four days after delivery, cyanosis, abdominal distention and respiratory depression suddenly became evident. No abnormality was seen on a portable plain film study of the abdomen. Saline enema, rectal tube, streptomycin and aqueous penicillin were instituted. The infant expired five days after delivery.

At autopsy, about 100 milliliters of turbid fluid containing solid white flecks were seen in the peritoneal cavity. A mass of clotted milk was found near the greater curvature of the stomach, lying free in the peritoneal cavity.

There were numerous fibrinous adhesions among the loops of small intestine. The esophageal mucosa was injected and contained curdled milk. The proximal portion of the greater curvature of the stomach contained a defect, 2 centimeters across in its greatest dimension. The edges of the defect were dark purple and friable. The dark purple discoloration extended into the lienogastric ligament. Microscopically, the wall of the defect showed marked venous distention and thrombosis. No leukocytic reaction was evident. The gastric mucosa was eroded. There was no apparent muscular atresia. The lienogastric ligament showed venous congestion and thrombosis. There was congestion of the spleen and portal congestion of the liver.

Bird, Limper and Mayer [4] state that perforations of this character rarely show cellular reaction. Our own case would lend support to this view. The complete list of characteristics of neonatal ulcers (*i.e.*, in the first two weeks of life) as set forth by Bird and associates is as follows:

1. The great majority bleed seriously, perforate, or do both.

Acknowledgment is made to Dr. J. J. Sullivan of Bloomsbury, New Jersey, for cooperation in, and permission to publish this report.

2. In many, the onset is precipitous, without promonitory signs or symptoms.
3. Intracranial injury and generalized sepsis are rare.
4. The lesions are acute, and there is neither cellular reaction nor bacterial invasion.
5. Owing to the sudden, acute, fulminating symptoms, very few cases come to operation.
6. Duodenal ulcers are more frequent than are gastric ulcers. The ratio is about 2 to 1.
7. The number of males affected is not impressively greater than is the number of females.

With respect to intracranial damage, however, Lemak [8] made a study of 18 cases. He says that half of the cases of gastroduodenal ulceration in the newborn show brain damage. Yet, the most recent report [1] contains only two which showed intracranial bleeding, and the authors doubt that it played a causative role in the ulceration.

The relative infrequency of bacterial invasion is supported by the same authors. They found overwhelming septicemia with ulceration and necrosis of the stomach wall in only two cases.

Pendergass and Booth [3] cite cases of Hibbard and Theile in which there was no inflammatory reaction. The case which they report had an operative repair of a ruptured stomach. The infant died two days postoperatively and was found to have had a second perforation of the stomach. Neither the perforation found at autopsy nor that which had been closed surgically showed any inflammation.

The foregoing, as well as the obvious difficulty in making a prompt diagnosis, indicates why the salvage rate is so poor in these patients. Vargas and his associates [1] found only nine survivors in the 22 recorded cases in which operation was done.

ETIOLOGY

Among possible etiologic factors Pendergass and Booth [3] mention hemorrhage into the mucosa during parturition with subsequent autodigestion (Adler), a possible infectious origin resulting in disturbances in circulation and autodigestion, and congenital defects in the stomach. Both Theile and Fenwick (according to Pendergass and Booth [3]) cite direct trauma (*e.g.*, gastric tube) as a factor. Herbut [2] reported a case in which rupture occurred as the result of congenital absence of muscle layers from the gastric wall. Burnett and Halpert [6] found pyloric atresia associated with perforation of the stomach in a newborn infant. They felt that the underlying cause of the perforation was a congenital defect in the wall of the stomach.

Vargas and associates [1] review the earlier opinions concerning etiology. They state that the peptic ulcer was, until 1943, regarded as the underlying lesion in all cases of perforation. Bird and his co-workers [4] then concluded that, while it was almost always the cause of duodenal perforation, peptic ulcer accounts for fewer than one-half the cases of gastric perforation in the newborn.

Since Herbut's report in 1943, Vargas, *et al.*[1] have found ten additional cases of rupture of the stomach in the newborn associated with muscular defects. All had tears along the fundic half of the great curvature. In addition, there were two cases of perforated gastric diverticula which these authors regard as variants of the same anomaly. Proved congenital muscle defects accounted for two of the cases of Vargas and his associates; two more, who survived operation, probably had muscle defects. The appearance and location of many of those cases in which no cause for perforation was found suggest that some type of muscle defect was present.

Abdominal trauma during delivery has been suggested as a possible cause of rupture of the stomach in the newborn. However, no verified case has been reported.[1] Further, it is difficult to conceive of a serious injury resulting from compression of a collapsed viscus. Usually air does not enter the gut until after birth.

Besides Burnett and Halpert's case,[6] Quinn [7] has reported distal obstruction associated with rupture of the stomach. In the latter case, the

obstruction was attributed to hypertrophy of the ileocecal valvular musculature as well as of the pyloric musculature. Quinn[7] also cites a second perforation causing death following apparently successful surgical repair of a perforation. Vargas and associates[1] report atresia of the ileocecal valve in one of their own cases; however, they attribute rupture in this case to the postoperative gastric tube.

Gastric intubation has been implicated in cases of aspiration or of gavage. Vargas' group feel that three of their own cases fall into this category.[1]

Six of the ten cases reported by Vargas and his co-workers were in premature infants. The authors state, further, that more than one-half the previously reported cases have been in prematures.[1] Since only about 6 per cent of live-born infants are premature, perforation is more frequent among the premature.

When one finds a number of causative factors proposed for a disorder, many of which are admittedly hypothetical, it is in order to seek an entirely different etiology. It is easy, for example, to accept distal obstruction combined with a muscular defect of the stomach wall as the cause of rupture or perforation. Yet, how often has one heard of perforation of the gut in cases of infants born with imperforate anus? There are, after all, many cases of imperforate anus and of diverticulosis of the colon. We must assume that they have occurred together in the same individual at some time. As a matter of fact, there are many more cases of atresia of the gut than there are of perforation. Still, we find a respectable proportion of perforations in infants in whom no evidence of obstruction or of muscular anomaly can be found.

Perhaps if we consider this lesion in the light of our present knowledge of complications occurring during therapy with steroid hormones we can find a clue. Individuals receiving cortisone are prone to perforation of pre-existing peptic ulcers. Experimental administration of steroid hormones to normal volunteers has resulted in production of peptic ulcers.[8] Trauma (and birth is traumatic) stimulates the production of steroid hormones to create what Selye[9] has termed "the general adaptation syndrome." To add to this, there is the postulate, again by Selye,[9] that the "local adaptation syndrome" is reduced in the presence of the "general adaptation syndrome."

It is also of interest that a very large proportion of the infants who perforate are premature. This, too, is a situation in which one could logically expect the "general adaptation syndrome" to come into play.

In the event that these perforations are the result of excessive cortisone production, why do all infants, particularly the premature, not perforate—or at least have ulcers? It is easy enough to answer the first part of the objection: the stimulus did not act over a long enough time, or its intensity was insufficient. None of the subjects in the experimental production of peptic ulcers perforated;[5] steroid hormones were stopped as soon as signs or symptoms appeared. There is considerable difficulty in diagnosing a perforation in a newborn infant, and the diagnosis of an uncomplicated ulcer is far more difficult. Further, it is well established[10] that ulcers do occur in children and in infants.

PROGNOSIS

Vargas and associates feel, with some justification, that more infants with perforation will survive as we become increasingly aware of the possibility of such a complication in the newborn. According to these authors,[1] Stern and his associates were the first to report, in 1929, the surgical repair of a perforated gastric wall in a newborn infant. One-half the cases reported since 1929 have died without the diagnosis being suspected. In the five years preceding the Vargas report, fourteen of sixteen came to operation, and nine survived. That these infants must come to operation to survive is obvious. The infant has not even the well-developed omentum that can, on occasion, save the adult with perforation of the gut by walling off the defect, without operation.

DIAGNOSIS

THERE is a long list of diagnostic criteria for this condition. It is composed, largely, of elaborations upon a few basic features that are present in all cases of perforation. These are:

1. Acute abdominal distention and respiratory distress.
2. Radiologic evidence of free air in the peritoneal cavity.

The first is very likely to occur in an infant whose neonatal course has been previously uneventful. The latter should be sought in a film taken in the erect position.

While Vargas and his group[1] feel that salvage will improve with increasing awareness of the condition, a final word of caution is in order. There have been cases that have come to operation which have died owing to failure of closure of the perforation or owing to development of additional perforations, or of both. These phenomena closely resemble the changes caused by steroid hormone therapy. The surgeon must bear in mind that the tissue with which he is dealing is not necessarily the same as that which he finds in the case of an adult with a perforation. He must excise enough of the wall of the defect to appose tissues that will heal.

185 Roseberry Street

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Drug-Induced Gastric Hemorrhage

The effectiveness of some drugs* in certain states should not blunt awareness of potential hazards associated with their use. In the course of one year, the authors* encountered 5 patients with upper gastrointestinal bleeding (with or without demonstration of ulcer) associated with one or the other of these agents: (1) reserpine, (2) phenylbutazone, (3) steroid, (4) salicylates. Trade designations of the agents involved were Serpasil (Ciba), Butazolidin (Geigy), Cordex (Upjohn), and Sigmagen (Schering). Cordex is a combination of steroid and aspirin; Sigmagen also contains saalicylate. Doses were all within accepted therapeutic range. From this experience, the authors say, it is apparent that promiscuous use of some of the newer drugs may have a deleterious effect on the digestive tract, either reactivating an old peptic ulcer or starting a new one. Such a lesion may bleed or perforate, creating a surgical emergency with attendant risk. Questioning the patient about previous ulcer symptoms may be of help in preventing unfortunate experiences with such agents. The exact mechanism whereby these medications produce such bleeding is not entirely understood. The most likely causes are (1) increased gastric secretion leading to peptic erosion and ultimate bleeding; (2) a local factor consisting of injury to the mucus-secreting cells or blood vessels of the gastric mucosa and consequent lowered tissue resistance; (3) a hypersensitivity reaction, with damage to the capillaries of the gastric mucosa; and (4) a humoral factor.

*Abstracted from an article by Gelfand and Goodkin in the July 15, 1958 New York State Journal of Medicine.

Historical Article • • •

FRED B. ROGERS, M.D.

Trenton

"To Repeal All Medical Laws . . ."

No medical society in the New World has its roots imbedded as deeply in our history as The Medical Society of New Jersey. Dr. Rogers, the Archivist of our Society, here throws light on one little corner of this long history.

DR. THOMAS W. HARVEY of Orange, N. J., recently presented the following letter, of unusual historical interest and over a century old, to the Archives of The Medical Society of New Jersey. Its author, Dr. William Pierson, Jr., (1830-1900)) whose legible handwriting survives in this communication, served as President of our Society in 1900. His father, Dr. William Pierson (1796-1882), also of Orange, was President in 1869. The addressee, Dr. J. Henry Clark (1814-1869), was a well-known physician in Newark. Dr. Pierson practiced for many years in the same offices that Dr. Harvey uses today. The latter's father, Dr. Thomas W. Harvey (1853-1938), was President of the Society in 1918. Historical items such as this letter, preserved in the Archives, will be of great value for the coming Bicentennial History of The Medical Society of New Jersey in 1966.

Orange, Feb. 15, 1858

Doct Clark

Dr Fr

In reply to yours of the 13th. I have to say that I fully concur in the opinion expressed by yourself and others, that the Charter is valueless to the profession of this State. All that remains to us, beyond what the Med. Soc. could accomplish for itself, is the right of conferring the degree of M.D. & fees derived from Licenses, upon which the pecuniary means of the Soc. have hitherto been dependent. The movement referred to by Doct. Phillips, I have no difficulty in tracing to the source. You will recollect that this very thing was publicly threatened by that man Skelton of Trenton at our last meeting.

But notwithstanding the freedom and distinctiveness of the foregoing opinion, I think it would not be proper or expedient that a few individuals in their private capacity should undertake to act for the Society, and therefore cannot advise to the course suggested by Doct. Phillips. Should the movement be persisted in, I think a special meeting had better be called, and the wish of the entire State ascertained. For one I have but a single favour to ask of the Legislature and that is to repeal all medical laws and leave the profession to stand or fall upon its own foundation. And this favour, I would defer until we reach the centennial anniversary of our existence. On that occasion I would make it the special business of the day. What a crowning glory would it be, to then say to our Legislature, Gentm. we thank you for all past favours but desire no more of them, especially such favours as ignorance, empyricism & malice would confer?

Yours sn

W. Pierson

P.S. In case of repealing the Charter, what will become of your fee bill, or rather of what avail will it be —

The text of the above letter pertains to contemporary problems of professional education, medical licensure and legal right of The Medical Society of New Jersey. This body, the oldest of its type in the United States, has long been a leader in health progress. The particular issues and physicians mentioned in this letter are worthy of comment because of their historical importance.

Authority to award the degree of Doctor of Medicine, granted to the Society by the State Legislature in 1825, was exercised sporadically until the beginning of the present century. This function was preserved in subsequent Charters and By-Laws of the Society, notably those of 1851, 1866 and 1896. Articles describing these medical degrees have appeared in the JOURNAL in November, 1953, and June, 1956.

"Doct. Phillips," mentioned in the correspondence, was Dr. John H. Phillips (1814-1878) of Pennington, President of our Society in 1851-2, the year in which a revised charter, preserving the M.D. granting right, was obtained. Dr. Pierson was a champion of this diploma-awarding jurisdiction, as noted in this letter of 1858. Speaking later before the Centennial Meeting at the Rutgers College Chapel in 1866, he urged the Society to award the M.D. diploma to deserving medical apprentices in New Jersey. By granting this degree, he stated, "We place our students upon an equal footing with those of other states, favored with medical colleges; and maintain, by a judicious method of conferring the degree, the standard of qualification for membership and practice."

"That man Skelton of Trenton," apparently Pierson's opponent at a Society meeting, was Dr. Charles Skelton (1806-1879), remembered today for his zeal in promoting public education in his home city. Born in Bucks County, Pennsylvania, he was graduated from Jefferson Medical College before settling at Trenton in 1841. His interest in the welfare of the poor, and laboring people led him to organize a free public school at Trenton in 1844; three years later he became city superintendent of schools. He was then elected to serve his district as Democratic congressman. Dr. Skelton was active in promoting early public school education and child labor legislation. The Charles Skelton School at Trenton was named in his honor in 1876; this building, at 212 Center Street, is now the Boys Club Center, Skelton Branch. Much interested in the diffusion of practical knowledge, Dr. Skelton left a sizeable bequest for the Trenton Free Library's purchase of technical and non-fiction books. Volumes purchased by this fund still carry a bookplate honoring their donor. The Skelton Branch of the Trenton Free Public Library, at South Broad and Malone Streets, also recalls his memory.

601 Edgewood Avenue

A Lump in the Throat

The sensation of a lump in the throat is a common complaint and is generally treated lightly. To assume that it is purely "functional" without scrupulous examination is dangerous. The emotional lump in the throat is probably a spasm of the cricopharyngeus muscle. This muscle serves normally as the sphincter of the esophagus. The lump which moves up and down, says Tremble,* commonly represents the results of inflammation of the nasopharyngeal mucosa after influenza. The lump with aching is most often found in women and is associated with hypothyroidism. In the case presented,* however, a lump that had been assumed at first to be "functional" and later ascribed to chronic lingual tonsillitis, was ultimately found to be a squamous-cell carcinoma on the tongue at the level of the tip of the epiglottis. The discomfort connected with pharyngitis is not necessarily proportional to the extent of the pathological changes found on examination. The temptation to explain a lump in the throat as a sort of organ "neurosis" should be resisted. The practitioner, urges Tremble,* must use all the means at his disposal to make a diagnosis and give appropriate treatment.

*Tremble, G. E.: Arch. Otolaryngology, 70:157 (August) 1959.

Obituaries • • •

DR. FRED F. DURRAH

A heart attack took the life of Dr. Fred F. Durrah of Plainfield on October 8, 1959. Born in South Carolina in 1883, Fred Durrah lived on a farm with almost no formal education until he was 15 years old. He engaged in ceaseless self-study and was able to matriculate at Howard University at the age of 26. After receiving his baccalaureate degree he was admitted to the medical school there and won his M.D. in 1913. He interned at Freedman's Hospital in Washington and late in 1914 he opened his office in Plainfield, N. J. There he remained for 45 years serving the people of that area. He was affiliated with the Muhlenberg Hospital. He was a director of a local Building and Loan Association, and a functionary in the Plainfield Chamber of Commerce. He was on the Board of Trustees of the local NAACP. In 1953, Dr. Durrah was the guest of honor at a testimonial dinner given by 300 friends in all walks of life.

DR. MELBOURNE E. W. GEORGE

Dr. Melbourne E. W. George, a well-known Essex County expert in industrial medicine, died on October 19 at the age of 60. Born in Missouri, Dr. George was graduated in 1926 from the Jefferson Medical College of Philadelphia. After completing his internship, he opened an office in Newark for general practice and remained in that city until 1955 when he moved to Verona. Dr. George was active in the affairs of the Essex County Medical Society and was on the medical staff of the Travelers Insurance Company.

DR. WILLIAM B. McGUINN

A heart attack on the golf links took the life of Dr. William B. McGuinn on October 28, at the age of 54. Born in Brooklyn, he received his M.D. degree at Long Island in 1935. After interning at Kings County Hospital in Brooklyn, he became a ward physician at the State Hospital there, and then from 1939 to 1941 did general practice in East Orange. He then entered military service, rising to the rank of major as a headquarters command surgeon in the Mediterranean theatre. On returning he joined the medical staff of Bell Telephone Company, and rose rapidly, becoming medical director of the entire New Jersey Bell Telephone Company in 1955. Dr. McGuinn was active in the affairs of the Essex County Medical Society, the Academy of Medicine, and the Industrial Medical Association.

DR. LAWRENCE H. ROGERS

One of the Delaware Valley's best known physicians died on October 14 with the passing on that day of Dr. Lawrence H. Rogers, medical director of the Donnelly Memorial Hospitals at Trenton. Born in Tullytown, Pa. on August 30, 1883, he received a bachelor of arts degree at Princeton in 1904 and his M.D. at New York University four years later. Following postgraduate study in Berlin and Vienna, he interned at Bellevue Hospital in New York City. He began practice with an uncle, Dr. Benjamin H. Rogers, in Paterson. Another uncle, Dr. Elmer H. Rogers, practiced in Trenton, where his nephew joined the staff of Mercer Hospital in 1912. He was visiting physician to the Mercer Hospital until 1931. Dr. Lawrence Rogers became Trenton City Physician in 1913 and served at a 20-bed city-owned hospital known as "The Municipal Colony." He was to make this institution his life work. Eventually it became the Donnelly Memorial Hospitals, and Dr. Rogers was appointed its medical director in 1925. The next year he collaborated with Dr. Haven Emerson of New York City on a health and hospitals survey of Trenton.

Dr. Rogers interrupted his tenure to enter the Army Medical Corps in 1917, and returned in 1919 to continue his work in Trenton. He served as president of the Mercer County Medical Society in 1920. He was a pioneer in the field of communicable disease control, and wrote on problems in diphtheria, scarlatina and poliomyelitis. As the Municipal Colony grew to a complex of hospitals, the medical director's field of interest broadened and he became known for his work in geriatrics and in convalescent and chronic care. A building for aged and infirm patients at Donnelly was named in his honor in 1954. Commenting on his death, Mayor Holland of Trenton said: "Dr. Rogers' career is largely the history of Trenton's care of its ill and aged."

DR. ANTHONY J. TRIARSI

One of Elizabeth's best known family doctors died on October 30 at the Alexian Brothers Hospital. Dr. Anthony J. Triarsi, a 1934 graduate of Georgetown University Medical School, was affiliated with all three hospitals in Elizabeth. He was born in that city in 1906 and served as a major in the medical corps on foreign duty in World War II. Dr. Triarsi served the Elizabeth Board of Health for over 20 years and was closely identified with the development of "baby-keep-well" stations in that area. He was also active in the affairs of the Union County Medical Society.

Announcements • • •

General Practice Symposium

On Saturday, January 9, 1960, a symposium on diagnosis in general practice will be held at the Traymore in Atlantic City. The morning session (starting at 10 a.m.) will be devoted to two papers: one on diagnostic gastro-enterology; and one on laboratory diagnosis. After luncheon there will be three papers starting at 2 p.m. The first will discuss blood disorders; the second collagen fiber disease; the last paper is entitled "Practical and Impractical Methods in Cardiac Diagnosis."

Five hours credit (Category 1) is allowed by the AAGP. The session is sponsored by the New Jersey chapter of the Academy. For more details write to Academy of General Practice at 120 Halsted Street, East Orange.

Baby sitter service will be available together with an attractive special program for wives.

Ophthalmologic Conference

A 3-day conference on ophthalmology will be held in Philadelphia February 18, 19 and 20, 1960. This is under the auspices of the Wills Eye Hospital and the Ophthalmological Section of the Philadelphia College of Physicians. For further details write to I. S. Tassman, Chairman, Wills Eye Hospital, 1601 Spring Garden Street., Philadelphia 30.

Treatment of Amblyopia

Announcement is made of a course in the treatment of amblyopia from March 7 to March 18, 1960, at the New York Eye and Ear Infirmary. This is limited to 20 physicians and the tuition fee is $100.

A series of three lectures on the treatment of amblyopia is also available on March 21, March 22 and March 23, 1960 for a fee of $25 for the course. Interested physicians should apply to the Registrar at the New York Eye and Ear Infirmary, 218 Second Avenue, New York 3.

Pediatric EENT

A 4-day symposium on ophthalmology and otolaryngology for children will take place at the New York Eye and Ear Infirmary April 4 to 7, 1960. A full program may be obtained from Dr. John R. Finlay at 218 Second Avenue, New York 3.

Arthritis Fellowships

Announcement is made of the availability of fellowships for the clinical study of arthritis. The physician should submit a program of proposed full-time study in a hospital or other research institution where he expects to devote his time to arthritis or related diseases. Financial support for the Fellow will be provided at the rate of $4500 a year with an additional $500 a year for each dependent. The organization also will pay towards tuition fees.

For further details, write to the National Foundation at 800 Second Avenue, New York 17, New York.

Pamphlets for Parents of Crippled Children

Announcement is made of the availability of six pamphlets for the parents of crippled children. These may be obtained at twenty-five cents each by writing to the National Society for Crippled Children, 2023 West Ogden Avenue, Chicago 12, Illinois.

Pamphlet No. 1: Why Did This Have to Happen?
Pamphlet No. 2: Your Child's Play.
Pamphlet No. 3: Toward Understanding Stuttering.
Pamphlet No. 4: You Are Not Alone.
This pamphlet tells how to find help for crippled children. It is a resource manual.
Pamphlet No. 5: Building An Estate for a Crippled Child. This explains how to provide for the financial future of the child.
Pamphlet No. 6: Bright Promise.
This is intended for parents of children with cleft lip and cleft palate and illustrates successful surgical repair procedures.

Training in Industrial Medicine

The University of Cincinnati offers graduate fellowships in industrial medicine. This provides professional training for M.D.s who have completed an internship.

The three-year program leading to the degree of Doctor of Industrial Medicine satisfies the requirements for certification in Occupational Medicine by the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in industrial medicine. A third year is spent as resident in an industrial medical department or in some comparable organization.

Stipends for the first two years vary from $3,000 to $4,000 depending upon marital status. In the final year, the Fellow is compensated by the organization in which he is completing his training.

Two other programs of study are offered to qualified applicants. A one-year course is available to applicants who wish to become candidates for the degree of Master of Science. In addition, a three-year academic program, leading to the degree of Doctor of Science, is available to those who wish to pursue careers in teaching and research. A number of fellowship stipends is available to candidates in these programs also.

Requests for additional information should be addressed to:

INSTITUTE OF INDUSTRIAL HEALTH
College of Medicine
Eden and Bethesda Avenues
Cincinnati 19, Ohio

Journal of Nuclear Medicine

In January 1960 there appears for the first time an English-language journal for the the atomic age. Called *The Journal of Nuclear Medicine*, it has an all-star board of editors. Annual subscription may be obtained by sending $10 to Samuel N. Turiel at 430 North Michigan Avenue, Chicago (11), Illinois. The journal focuses on diagnostic and therapeutic applications of radio-isotopes and radiobiology and on all subjects relevant to nuclear medicine. Dr. George E. Thoma of St. Louis is the editor.

Medical Writing Contest

April 1, 1960 is the deadline for articles to be submitted by interns and residents to the Delaware Valley Chapter, American Medical Writers Association. For details, write to Dr. D. C. Geist at 1930 Chestnut Street, Philadelphia 3, Pennsylvania.

American Academy Prizes

A $1000 prize will be awarded in 1960 to the author of the best monograph in the physical or biologic sciences. A monograph is here defined as a scholarly contribution to knowledge too long for a journal article, too specialized for a general book. Deadline for submission of manuscripts is October 1, 1960. For details send a stamped, self-addressed envelope to Monograph Prize Committee, American Academy of Arts and Sciences, 280 Newton Street, Brookline, Boston 46, Mass.

Camden County Organizes AAGP Chapter

On November 1, 1959, a group of Camden county physicians met in Collingswood to organize a chapter of the American Academy of General Practice. The AAGP is now the second largest medical association in the nation. More than 25,000 doctors belong to the AAGP. Members of this society are pledged to continue their medical education, to keep abreast of current advances in medicine and surgery and to maintain high standards of practice. Officers of the new Camden County chapter are:

E. R. Rosner, M.D., Collingswood, N. J., *President*; Vincent S. Palmisano, M.D., of Runnemede, *Vice-president;* and J. J. Blake, M.D., of Haddon Heights, *Secretary*. Also elected at the organization meeting were members of an executive committee: Doctors Paul Cohen, J. S. Klinger, Henry Price and Frederick W. Strauss. For further information, write to Dr. Joseph J. Blake, 111 Fourth Ave., Haddon Heights, N. J.

County Society Reports • • •

Atlantic

A regular meeting of the *Medical Society of Atlantic County* was held on October 9 at the Children's Seashore House. Dr. Louis Rosenberg presided over the meeting at which Mr. Vincent Brown discussed the Medical-Surgical Plan. The discussion covered different facets in public relations and other aspects of Blue Shield services.

Dr. Peter Marvel read a resolution on the death of Dr. Rostin White and Dr. David Allman read another on the death of Dr. David Berner.

The Medical-Legal Liaison Committee reported that the National Interprofessional Code for Physicians and Attorneys has been adopted by the American Medical Association, the American Bar Association, and The Medical Society of New Jersey. Our Society also approved it.

Dr. Max Gross, chairman of the Public Health Committee, discussed Atlantic City's pigeons. A resolution was passed urging better pigeon control in Atlantic City.

The Emergency Medical Service Committee reported that 95 calls had been handled by Drs. McKnight, Mann, and Kramer. It is planned to have a new telephone number especially for the emergency service, and to publicize this number in the near future.

Dr. Victor Bressler, speaking for Dr. Robison Harley, reported for the Public Relations Committee. He stated that the enthusiasm which the public had shown the *Capsules of Medicine* articles in *The Atlantic City Press*, had been very fruitful.

The formal business meeting was adjourned, and the doctors then met with their ladies of the Auxiliary to enjoy a delicious collation, and to listen to a delightful presentation by Mrs. Ruth Stein who sang popular songs from a number of successful Broadway musicals, accompanied at the piano by Mrs. Nathan Hoffman.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society*, held October 13 at Bergen Pines Hospital, Paramus, was called to order by Donald B. Hull, M.D., President, at 9:15 p.m.

Minutes of the regular September meeting and those of the Executive Committee meeting of September 22, were accepted as printed in the October 1959 *Bulletin*.

The following members were elected: *To Regular by Transfer*—Joseph V. Hayden (from Hudson Co. Med. Soc.); Irving Innerfield (from Med. Soc. Co. of Rockland, N. Y.); Sol M. Papperman (from Orleans Parish Med. Soc., New Orleans); Ben Shiener (from Passaic Co. Med. Soc.); *To Associate*—John F. Barret, Bernhardt W. Hausheer, Arthur W. Jacoby, William A. Layman, Giulio Mondini, Mario L. Pesaresi, Arthur D. Pesin, Jaroslaw Rozankowski, Jerry Weisberg.

The Chair asked the Treasurer to discuss the salient features of his financial report printed in the October 1959 *Bulletin*. At the conclusion of his discussion, there being no questions, it was agreed that the Treasurer's report would be accepted and filed.

In the absence of Dr. Fitzpatrick, Chairman of the Budget Committee, Dr. O'Connor, a member of the committee, called attention to the report of the Budget Committee, which had been approved by the Executive Committee and printed in the current *Bulletin*. The Treasurer discussed each item, and on motion, the report was accepted and the proposed budget was adopted.

Two memorial resolutions were read and unanimously approved. One was on the death of Dr. Joseph S. Van Dyke and the other on the death of Dr. Reuben M. Anderson.

Dr. R. B. Berlin, chairman of Public Health, reported on a meeting in Trenton, which he attended accompanied by President Donald B. Hull. This was a meeting of the N. J. Public Health Council in which a panel of seven members of the Council heard reactions from the floor to a recommended code for new law governing municipal health departments. More than a hundred attended the meeting and varied reactions were given. Dr. Berlin reported that the basic idea of the new code was approved but that in many places, a detailed examination showed the result of the lack of the presence of a physician or physicians on the Council which drew up the code. Dr. Berlin reported further, that this Code as written, for all practical purposes, would eliminate some of the major functions of the State Department of Health and would throw expensive and almost impossible responsibilities on local and municipal departments of health. This code will require extensive and detailed scrutiny and revision before it can be satisfactory to the physicians and to the hundreds of municipalities.

Dr. Campbell, Chairman of this Society's Committee on Civil Defense and Disaster Control and Deputy Director for Health of the Bergen County Civil Defense Organization, called attention to a letter received from the Passaic County Medical Society, highlighting the role of the county medical society by calling a meeting to put that county's program in operation. He pleaded with members to check with their local coordinator and to sign up for this service.

The Chair turned the meeting over to Dr. Samuel B. Reich, Chairman of the Program Committee, who presented Dr. Joseph W. Jailer, Associate

Attending Physician, Presbyterian Hospital-Associate Professor of Clinical Medicine, Columbia University. Dr. Jailer discussed the recent advances in the diagnosis and treatment of Cushing's syndrome. Detailed notes on his address are filed in the Business Office.

There being no further business, the meeting was adjourned to collation at 10:50 p.m.

On November 10 the *Bergen County Medical Society* held a session at Bergen Pines, under the chairmanship of Dr. D. B. Hull, president. Elected to membership were Doctors Samuel Clark, Anna Herman, R. G. Kerdasha, Jack W. Moss, R. J. Veenema, and Daniel Roth.

It was reported that a group of osteopaths were advertising on a house to house personal call basis in Saddle Brook, that all physicians may care for their patients in the "Saddle Brook General Hospital" now under construction. The question was raised about a possible newspaper release informing the public that members of the Bergen County Medical Society, The Medical Society of New Jersey, and the American Medical Association are not permitted any voluntary professional relationship with cultists, and that therefore it will not be possible for a resident under the care of a member of this Society to be hospitalized in the new institution. After brief discussion, the Chair referred this inquiry to the Public Relations Committee for appropriate action.

Dr. Palazzo, Chairman of the Insurance Committee, discussed a proposed rider to Blue Cross contracts, which would extend coverage to hospital out-patients for x-ray, pathology and certain other medical services. Dr. Palazzo suggested that this would further increase the cost of hospitalization insurance, encourage hospitals to practice medicine, place the hospital in competition with private practitioners, jeopardize the principle of free choice of physician; and that it is unnecessary because these services are now covered under a new Blue Shield rider. A resolution opposing the new Blue Cross rider was moved. After full discussion, during which a vote to table the resolution was defeated, the motion being duly seconded, was passed.

The Chair exhibited a certificate of appreciation from the Third District of the New Jersey First Aid Council, which reads: "Certificate of appreciation to Bergen County Medical Society—This certificate is tendered for your assistance rendered during the year 1959." It relates to the services of five of our members who delivered lectures on five general types of medical emergencies.

The Chair turned the meeting over to Dr. S. B. Reich, Chairman of the Program Committee, who introduced Mrs. Kathleen Sletteland of the Public Health Council; Dr. Miriam Sachs, District Health Officer, State Department of Health and Miss Gertrude Eckhardt, Executive Director, Bergen County Tuberculosis and Health Association. He then presented Dr. Jesse B. Aronson, Director of Division of Local Health Services of our State Department of Health, who discussed a report compiled by a committee of local health officers which is now being considered for adoption by the N. J. Public Health Council. Copies of a summary of this report and the philosophy behind it are available at Society Headquarters to any member who wishes to request same. A lively question and answer period followed Dr. Aronson's presentation. At the conclusion of his presentation, the representative of the State Department of Health was warmly thanked by both Dr. Reich and the Chair for his extremely interesting and timely report.

There being no further business, the meeting was adjourned to collation at 10:45 p.m.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

The second regular meeting of the *Burlington County Medical Society* under the chairmanship of President Edward Haldeman met at the Millside Dairy, October 8. Robert Robbins, M.D., Director of Radiologic Therapy, Temple University, presented a paper on radiologic therapy in the treatment of malignant disease.

Mr. Vincent Brown of the Medical-Surgical Plan of New Jersey, then spoke of the new coverages under the plan. He stressed that the plan cannot pay for diagnostic work in hospital. Some members felt that a more thorough educational program was needed to familiarize subscribers with the limitations of their policy, as well as with its advantages.

There then followed a discussion of alleged advertising by new physicians, especially in the Levittown area. No action was taken. There was also considerable discussion about the canon which said that there should be no "voluntary association with osteopaths." This is obviously impossible of literal application as one must read their x-rays, report their laboratory work, etc. It is difficult to know where to draw the line.

Dr. George Flamm of Beverly, and Dr. Gullingsrud of Medford Lakes were elected into membership in the Burlington County Medical Society

LINDLEY B. REAGAN, M.D.

Reporter

Cumberland

The October meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake, N. J., at 2:00 p.m., Tuesday, October 13, 1959, with the president, Benjamin Berkowitz, M.D., of Bridgeton, in the chair.

Ralph Phillips, M.D., of Bridgeton, Chairman of the Diabetic Detection Drive, presented his committee's plan to execute the drive. Each physician is expected to render a public service by

testing urine in his office without fee during the week of the drive.

Jesse Carl, M.D., of Bridgeton, reporting for Gabriel Tatarian, M.D., of Bridgeton, summarized the findings of the Perinatal Committee, substantiated by statistics taken from our local area. A history of the origin of this research group was also included.

The main speaker, Mr. James Zotti, Assistant Director of Physicians' Relations of the Medical-Surgical Plan of New Jersey, clarified the existing plan's policies.

The meeting adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on November 3. Dr. Charles E. Rosen presided.

The guest speaker was Dr. M. Henry Williams, Jr., Director, Chest Service, Bronx Municipal Hospital Center. Dr. Williams' topic was "Pulmonary Emphysema in Clinical Practice." Many members participated in a discussion from the floor.

The Society approved an amendment to the By-laws providing for the inclusion of the immediate three past presidents on the Executive Committee.

The Society passed the following resolution:

Whereas the Blue Cross contemplates coverage of diagnostic radiology and pathology services to be done in the hospital on an outpatient status; and

Whereas this encourages the hospital to participate in the private practice of medicine and places the hospital in direct competition with the private practitioner; and, what is most important to all practitioners, will further the encroachment of socialization into the private practice of medicine; and

Whereas this will increase the cost of Blue Cross coverage to the public;

We therefore resolve that the Hudson County Medical Society go on record as opposing this plan.

And we further resolve that the Hudson County Medical Society requests The Medical Society of New Jersey to go on record likewise as opposing this plan.

We further resolve that a copy of this resolution be sent to each component county society for their approval.

The following physicians were elected to membership: Drs. Michael Fushille, Peter F. Maurice, Stephen Nychay, Martin Sckalor, Pietro Stella and Wolodymyr Zankiw of Jersey City; Valentina Getmanov and Carol S. Hamilton of Wechawken; Frederic F. Primich and Frank C. Vanore of West New York; Christopher M. Martin of Cranford; and Arthur D. Zampella of Newfoundland.

Following the business meeting a collation was served.

ROY A. MORROW, M.D.

Reporter

Mercer

Dr. Daniel F. Featherston, Chairman, Judicial Council; Mr. Richard I. Nevin, Executive Officer; and Mr. Robert M. Backes, legal counsel, respectively of The Medical Society of New Jersey, addressed the members of our Society at its November 18th meeting on the subject of "Judicial Committee Functions at County and State Levels."

At the conclusion of their remarks, our visitors very graciously answered numerous questions relative to the mechanics of the Judicial Committee.

The business portion of the meeting was limited to the election of: Drs. William J. Dougherty and Bertram H. Frohman to Active membership; and Drs. Elmer Alpert and Thomas L. Evans to Associate membership.

Physicians elected to membership at our October 14th meeting were introduced to their fellow-members.

Refreshments were served by members of the Woman's Auxiliary at the conclusion of the meeting.

RALPH N. CAGAN, M.D.

Reporter

Middlesex

Under the chairmanship of Dr. John A. Smith, its president, the *Middlesex County Medical Society* held its first fall meeting of 1959 at Roosevelt Hospital, Metuchen, on October 21.

Dr. Coralyn R. Flad of New Brunswick, was elected to a two-year period of Associate membership.

Dr. B. Slobodien reminded the Society that members have only ten more days to apply for the Group Life Insurance Policy without undergoing a physical examination. It was also explained that membership in the Society Group for Blue Cross and Blue Shield is open until November 15. The dues assessments for 1960 were accepted without discussion, including the new State Society assessment of $13.33 for Associate members. The usual $5.00 "rebate" was authorized.

Dr. George H. Murphy, President of Middlesex General Hospital, gave a dynamic speech on "modern hospital management." His conclusion was that only through progressive and aggressive manage-

ment of all interested parties can better patient care be achieved and government interference blocked.

After long discussion on terminology of revision of the Constitution and By-Laws, Dr. C. H. Calvin requested that members mail him written suggestions on corrections and additions.

THOMAS I. STEINBERG, M.D.

Reporter

Monmouth

On October 28, Dr. Lester Barnett conducted a business meeting of the *Monmouth County Medical Society* which was held at the Fitkin Hospital. At this session the following were elected to active membership: Doctors M. L. Laporta, R. B. McCarthy, M. D. Panzer, and W. J. Zapcic. At the conclusion of the brief business meeting, the program committee took over and presented a discussion of "radiation therapy in mid-century." The colloquium was led by Dr. Harold W. Jacox, chief of radiation therapy at New York's Presbyterian Hospital.

DONALD W. BOWNE, M.D.

Reporter

Passaic

The Annual Installation Dinner Meeting of the *Passaic County Medical Society* was held in Paterson on October 7 to introduce Dr. Julian Cohen as President, and the other officers of the Society.

Dr. F. Albert Graeter, Chairman of the Dinner Committee, introduced George H. Talbot, D. D., who gave the invocation.

After the dinner, Dr. Graeter called upon Dr. Sandor A. Levinsohn, who served as Master of Ceremonies.

The retiring president, Dr. Theodore K. Graham, was presented with a plaque in appreciation of his services during the past year. He acknowledged this gift with thanks.

Dr. Julian Cohen, the newly installed president, then addressed the group. He emphasized the theme of "Improving public relations between the physicians and the public in Passaic County."

The other officers installed were: Dr. F. Albert Graeter, first Vice-President; Dr. David B. Levine, second Vice-President; Dr. Joseph E. Mott, Secretary; Dr. Frank B. Vanderbeek, Treasurer; Dr. M. Frank Kaletkowski, assistant Treasurer; Dr. Irving Chrisman, Reporter and Dr. John A. Ianacore, Editor.

Invited guests of the Society included Dr. F. Clyde Bowers, President, and Mr. Richard I. Nevin, Executive Officer, of The Medical Society of New Jersey, both of whom addressed the group briefly; also Dr. Donald B. Hull, President and Dr. Charles P. Campbell, Secretary, of the Bergen County Medical Society. Other guests included the Honorable Stanley Zwier, Mayor Clifton, Mrs. John F. Crane, Director of the Paterson General Hospital, Mr. Harvey Schoenfeld, Director of the Barnert Memorial Hospital, Mr. Joseph A. Mattson, Administrator of the Passaic General Hospital, Mr. David Wachs, Superintendent of Beth Israel Hospital, Miss Ruth Taylor, Administrator of Chilton Memorial Hospital, Mr. Harry B. Haines, Publisher of The Paterson *Evening News,* Mr. Henry A. Williams, III, Publisher of *The Morning Call,* Mr. Richard Drukker, President of *The Herald News,* Marvin A. Tucker, D.D.S., President of the Passaic County Dental Society, Mr. Frank E. Pondelick, President of the Passaic County Pharmaceutical Association and Bernard Feinberg, Esq., President of the Passaic County Bar Association. It was also a pleasure to have as guests the Emeritus Members of the Society who could attend: Doctors Andrew B. Vanderbeek, Charles R. Mitchell, Herman J. Udinsky and Louis Linton.

Dr. Levinsohn then introduced the guest speaker, Joseph Hirsh, M.D., Associate Professor of Environmental Medicine at the Albert Einstein College of Medicine, New York. Dr. Hirsh gave an interesting and enlightening talk on "The Medical Student, His Education, and the Image of the Physician."

IRVING CHRISMAN, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held on Friday, October 17, at the DuPont Penns Grove Country Club with Dr. George A. Nitshe, Jr., of Elmer, presiding.

Dr. Isadore Lipkin, Penns Grove, Chairman of the annual Diabetes Detection Week program, announced that test kits and informative material will be distributed to all county physicians. He requested that tabulated results be returned to the Chairman for correlation.

Dr. Harold I. Mark was named Chairman for the annual Shad Dinner which is held as the last regular meeting of the year. Dr. Ford C. Spangler, Salem, will be the program Chairman for this event.

Dr. Charles B. Norton, Woodstown, reported on the September meeting of the Council on Medical Services.

A request for endorsement by the Medical Society was received from the Board of Trustees of the Salem County Guidance Center. This endorsement was given approval by the members.

The guest speaker, Dr. Seymour H. Rinzler, professor of Cardiology at Columbia Presbyterian Medical Center, was introduced by Dr. Nitshe. Dr. Rinzler explained that New York City has a higher incidence of coronary artery disease than any other city in the country. New York State occupies the

same unenviable position in the list of states. A project is now underway to evaluate the effects of diets on cholesterol in the coronary arteries and the body and how changes in diet may change this level of cholesterol. The formulation of a Prudent Diet as developed by the project was discussed, and it was pointed out that there has been a ten per cent increase in consumption of fat calories in the average American diet during the past fifty years. Some of the causes for this increase include more widespread use of milk and milk products, increase in cooking fat usage and the trend toward meat products with higher fat content. The Prudent Diet is designed to reduce the level of cholesterol in the body. Further studies on this project during the next several years will attempt to correlate the role of the American diet to the prevalence of coronary artery disease in the United States.

G. F. REICHWEIN, M.D.

Reporter

New Jersey Orthopaedic Society

The Fall Meeting of the *New Jersey Orthopaedic Society* was held at Our Lady of Lourdes Hospital in Camden, on October 10, with Dr. Robert J. Neville as program chairman and moderator. The program consisted of a presentation of interesting scientific papers with extended discussion both from the chair and the audience of members and guests.

Papers were presented by Doctors E. V. Davis, Jerome Gelb, K. W. Haines, Bernard Halbstein, Philip Henneman, Luke Jordan, Otto Lehmann, Harry Merliss, Charles Nadel, Pedro Nunez and Spencer Snedecor. At the conclusion of the scientific program, a business session was held under presidency of Dr. R. R. Ciccone.

WILLIAM J. D'ELIA, M.D.

Reporter

Book Reviews • • •

The Ecology of Human Disease. Jacques May, M.D. New York 1958. M.D. Publications. Pp. 327. ($7.50)

Disease is here construed as a challenge to survival. The text studies transmissible disease in relation to its social, meteorologic and economic milieu. There are chapters on the ecology of several diseases—measles, trachoma, scarlatina, poliomyelitis, and so on. The book is weighted down by a good deal of unnecessary padding. For example, we read here that: "In Uganda, ankylostomiasis is found in 30 per cent of all stools from the Protectorate, whereas lower percentages are found at Kabale, while at Moroto, the rate is only 5 per cent." This sort of detail should have been edited out. If the reader is not heckled by the fantastically detailed statistical tables and by the padding of geographic minutiae, he will find here an unusual approach to disease, with emphasis on geography and climate. There is a certain freshness to the view that disease is a response to an environmental challenge.

A. BOHDANOWICZ, M.D.

Principles of Disability Evaluation. By Wilmer Cauthorn Smith, M.D. Philadelphia, 1959. Lippincott. Pp. 210. ($7.00)

In our industrial age, every physician may have to evaluate disability. If we are not to surrender this function to lawyers, adjusters or vocational experts, we doctors must learn the principles of evaluation. Hence a book like this is welcome.

The author warns the doctor not to be "influenced by the patient who is . . . unusually cooperative." He says that this is the attitude of the successful salesman and that the malingerer has a bill of goods to sell to the doctor. This leads to the implied (though not explicit) syllogism that the cooperative claimant is a malingerer! He insists that the physician "is not qualified to appraise the effect on an individual of shock . . . or loss of self-respect." Certainly these factors do produce disability, and one wonders who, if not the physician, is going to evaluate them.

Dr. Smith asserts that "the only valid yardstick with which to measure the disability is reduction in capacity to engage in gainful employment." He ignores all other kinds of disabilities. Furthermore he wants to limit evaluation to "short

range" effects only, fearful that a long-range prognosis would introduce other factors. He would deny a rating to the disability due to "tension and nervousness." Indeed, he makes the extraordinary statement that "functional effects have no specific etiology." This, he suggests, is because "psychiatry has never enjoyed the advantages bestowed on other branches of medicine by disclosures made at the autopsy or operating table." Dr. Smith's lack of sophistication about emotional disability is surprising. He seems to feel that anxiety, or phobias, or other emotional handicaps are not "real" disabilities.

Similar cynicism is revealed in his attitude towards severe disfigurement. Most of us believe that a repulsive scar is an industrial handicap—at least in job findings. But Dr. Smith says that, with respect to defects of appearance physicians have no qualifications to deal with the subject. "Consideration of the effect of disfigurement" he writes "must be eliminated."

The second half of the book, dealing with the technic of evaluation, is relatively free of the bias which so reduces the usefulness of the first half. The author spells out methods of evaluation and for orthopedic disabilities, this is admirably done. Brain, cardiac and respiratory disabilities get a once-over-lightiy in a grand total of 4 pages, while 70 pages are devoted to orthopedic disabilities.

This is a useful work for the orthopedist who wants to learn more about disability evaluation and who won't be too seriously influenced by the author's crotchets on the nature of causation and the criteria of disability.

HENRY A. DAVIDSON, M.D.

A Short History of Psychiatry. Erwin H. Ackerknecht, M.D.. Hafner Publishing Company, New York, 1959. Pp. 98. ($3.50)

Dr. Ackerknecht's personal orientation in psychiatry seems to be largely in the direction of social anthropology. This, of course, is a legitimate focus of interest, and it does tincture the book. Thus, all of 17th century psychiatry is covered in 4 pages, and the fruitful 18th century is raced through in 5 pages. But Pinel alone gets 8 pages. This curious variance in emphasis gives the book a somewhat jerky pace. The book ends abruptly; you turn the page to look for another chapter that isn't there. The nine pictures are quaint rather than informative. Dr. Ackerknecht discusses Greek, Roman, and Renaissance psychiatry; he concentrates on Esquirol, Pinel and the French School generally. There is a 5 page chapter devoted entirely to "the theory of degeneration," and then 13 pages on "German psychiatry of the first half of the 19th century." The discussion of psychoanalysis is compact and well-balanced. Modern somatic therapies are treated casually. The index is not good. For example, insulin therapy is briefly mentioned in the text but is not listed in the index. Although the book is a bit too superficial to satisfy the exacting reader, it does pack a lot of useful information in its 98 pages.

HERBERT BOEHM, M.D.

Diseases of the Colon and Anorectum. Edited by Robert Turell, M.D. Philadelphia, 1959, Saunders, 2 v. Pp. 1238 ($35.00 per set)

In the words of the editor these volumes are, "a practical—though not encyclopedic—text book on the function and diseases of the colon and anorectum." A brilliant and distinguished group of experts have been assembled and each has the opportunity to demonstrate his forte. Each author, with few exceptions, is lucid, thorough and explicit. Bibliographies for each article are extensive, correct and fairly complete.

The volumes are not well organized and the helter-skelter attempt at alignment of subject material is disconcerting. Negative criticism, other than the above, is too picayune to be printed. The volumes are recommended to the medical profession for study and reference. The authors are commended for their excellent presentations.

RICHARD A. HOPPING, M.D.

Cancer: Diagnosis and Treatment. Edited by J. B. Field, M.D. Boston 1959, Little Brown and Company. Pp. 796. ($18.50)

Cancer death reduction depends largely on early diagnosis and treatment. This book covers the conventional division into body regions—cancer of the chest, tumors of the breast, and so on. There is also excellent material on the medical care of the cancer patient, a special chapter on malignancies of childhood and good material on chemotherapy and radiotherapy. The authors are sensitive to the emotional problems of cancer management and even discuss what to tell the patient.

VICTOR HUBERMAN, M.D.

Biopsy Manual. By James D. Hardy, M.D., J. C. Griffin, Jr., M.D. and Jorge Rodriguez, M.D. Philadelphia, 1959. Saunders. Pp. 150. ($6.50)

This small new volume describes modern technics for obtaining valuable specimens of tissue from every part of the body. It is astonishing how much very useful information has been compressed into this slim volume.

The authors describe the uses, types and technics of biopsy: incisional, excisional, bite, aspiration, punch, trephine, curettage, scrape, sponge, and irrigation; common omissions, errors and complications of biopsy. Practical instructions are given about the use of instruments and fixatives; frozen section *vs.* paraffin sections. Also discussed: Papanicolaou smear and how to keep the proper records needed for pathology laboratory.

Excellent illustrations and charts are distributed liberally throughout the book aiding in the de-

scription of incisions, landmarks, regional anatomy, and lymphatic drainage. These help to protect the surgeon against dangerous complications during the performance of biopsy. The text also describes how to avoid such hazards as hemorrhage, spread of infection, severe trauma and dissemination of tumor cells.

This is strictly a manual of surgical technic. Methods of pathologic study are not included. It is a practical volume which will be of enormous value to any surgeon and to any practitioner who might have occasion to take specimens for biopsy.

WALTER K. SHELLEY, M.D.

Master Your Tensions and Enjoy Living Again. George S. Stevenson, M.D. and Harry Milt. New York, 1959. Prentice-Hall. Pp. 241. ($4.95)

We are physically safer than we ever were—yet emotionally, the whole age seems "shook up." George Stevenson, the distinguished American psychiatrist, and Harry Milt, a public relations officer, have jointly written this text on tension. They describe how tension is built up and give sensible advice on how to break tension. They discuss such technics as taking a positive step forward, getting rid of anger, doing one thing at a time, helping others, curbing the "superman urge" and talking it out. The book is salted with many brief case studies with which a reader can identify.

This is a sound, easily read volume, that can serve the medical practitioner in three ways. It constitutes wonderful source material for a public talk on tension. It is an excellent reading reference for over-anxious patients. And the doctor who is himself hag-ridden by tension can find help here.

FELIX UCKO, M.D.

Relaxation and Exercise for Natural Childbirth. By Helen Heardman. Ed. 2. Edinburgh, 1959, Livingston. Published in the United States by Williams and Wilkins of Baltimore. Paper 31. ($0.65)

For a half century obstetrical literature has focussed on surgical and technical craftsmanship. Indeed, this has paced the evolution of obstetrics out of midwifery. As a next evolutionary step, we welcome the concept that every woman can carry her child with grace of movement and poise of body. This pamphlet, written by an experienced physiotherapist, suggests that the daily practice of relaxation and training exercises will help every mother during and after delivery. Miss Heardman prefers to replace the negative-sounding phrase "labor pains" with the more accurate "uterine contractions." Certainly a squeezing uterus will be more painful to the unprepared woman than to the prepared one. The former will find that pain means tension and tension means fear—and this aggravates the pain.

The expectant mother can follow the exercises illustrated in this booklet. And if she does so, she will learn to relax when D-day comes. Of course, women react diversely to stress situations. Then, too, the experiences of a woman's own mother will influence her attitude towards pregnancy.

Every expectant mother can profit by a study of this brief booklet. It will help her realize a truly natural childbirth.

JOSEPH HOCHSTADT, M.D.

Now or Never: The Promise of the Middle Years. By Smiley Blanton, M.D., in collaboration with Mr. Arthur Gordon. Englewood Cliffs, N. J. 1959. Prentice-Hall. Pp. 273. No index. ($4.95)

Librarians now have a special catalogue number and shelf position for books on the subject of happiness. Most such books turn out, in practice, to be disappointing. Somehow the sonorous generalities don't seem to work out. However, the presses continue to pour out volumes on self-help to happiness. In this book, Dr. Blanton directs himself to the problems of people over 35. He discusses financial, sexual, physical, religious, and philosophical aspects of maturing and aging. He gives out neat packages of advice like: "re-evaluate yourself"; or "do the best you can and leave the rest to God."

ABRAHAM LEFF, M.D.

A Textbook of Medicine. Edited by Russel L. Cecil, M.D. and Robert F. Loeb, M.D. Ed. 10. Philadelphia 1959, Saunders. Pp. 1665. ($16.50 in the one-volume edition and $20.50 in the two-volume edition)

For more than 30 years Cecil and Loeb has been a standby in internal medicine. The medical public has given the book such an accolade, that it needs no bouquet from this or any other reviewer. The present edition for the first time, includes material on renal glycosuria, granuloma inguinale, steroid metabolism, carcinoidosis, hepatic coma, high altitude sickness and a dozen other new topics. All other subjects have been brought up to date (early 1959). In style, the book varies from the pedantic and prolix to the pleasant and practical, depending on the authors of the individual sections: and there are about 100 different contributors. The text is available in a fat volume, almost 3 inches thick; or in two slimmer volumes, at the buyer's choice. As usual, Cecil and Loeb joins the small and select company of truly "standard" works.

ULYSSES M. FRANK, M.D.

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INDEX -- 1959

HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject; book reviews by title or subject but not by author. City of residence is indicated for authors of original articles.

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The annual reports of the committees and officers of the Society and the Transactions of the Annual Meeting appear in the July issue.

TABLE OF PAGES

January	1 to 40	September	529 to 588
February	41 to 94	October	589 to 644
March	95 to 152	November	645 to 710
April	153 to 222	December	711 to 768
May	223 to 296		
June	297 to 362		
July	363 to 480	Annual Reports	July JOURNAL
August	481 to 528	Transactions	July JOURNAL

KEY TO SYMBOLS

* Original Article
† Obituary
e—Editorial
br—Book Review
ab—Abstract

INDEX 1959

A

A Votre Sante e42
Abdominal Wound, Penetrating—Ridley *566
Abraham, Albert, Morristown *733
Abscess, Pelvic, Following Appendicitis—Clemente *513
Ackley, David B.† 526
Aged, Discovery of e482
Aged, Peptic Ulcer in—Mason *542
Aging, Committee on 139
Aging, White House Conference 702
Air Pollution—Marin *629
Albano, Joseph† 579
Alcoholic, Hospitalization of e711
Alcoholism, Drug Control of ab729
Alcoholism in a General Hospital—Parry *725
Alcoholism, Treatment of—Rogers *247
Alexander, Leo, Letter from 525
Alfano, Nicholas F., Newark *647
AMA Delegates, List of (Advertising page 3A each issue of THE JOURNAL)
American College of Surgeons, Fellows 634
Aminophylline Poisoning in Childhood—Pollack *550
Amphetamine-Analgesic Combination in Arthritis—Strazza *124
Anatomy of the Nervous System(Ranson and Clark) br707
Anderson, Reuben M.† 526
Anemia, Pernicious ab490
Angiography, Cerebral—Kuhn *68
Animal Contacts and Skin Disease—Goldberg *et al.* *671
Announcements 32, 85, 142, 171, 287, 356, 374, 522, 580, 633, 702, 748
Annual Meeting, 193rd—
Annual Reports 380
Official Attendance 372
Program 177
Scientific Exhibit Awards 372, 571
Transactions 379
Anorectum, Diseases of (Edited by R. Turell) br755
Anoxia, Fetal, Prevention of—Nesbitt *719
Antihistamine in Allergies—Flothow *et al.* *733
Antihistamine Poisoning—Connolly *264
Antonius, Nicholas A., Newark *605
Aorta, Aneurysm of ab718
Appetite Control—Feldman *339
Areson, William H.† 285
Arlein, Myron S., D.V.M., Plainfield *671
Army-Navy Special Membership 517
Arrhythmias—Rosenberg *258
Arthritis, Treatment of—Strazza *124
Asthma, Occupational—Weiner *616
Atherosclerosis and Diet—Edwards, Caldwell and Zealand *300
Atlantic County Medical Society 34, 87, 145, 173, 288, 524, 750
Atomic Age and Cancer (C. A. Tavares) br149
Attorneys and Physicians, Code for 134, 568, 681
Audiometry in Litigated Cases—Goldstein and Rickenberg *507

B

Babies, Normal, Birth of (L. P. Strean) br527
Behavior, Neurologic Basis (Edited by Wolstenholme and O'Connor) br92
Berg, Samuel, Newark *81
Bergen County Medical Society 87, 145 173, 210, 375, 703, 750
Biber, David, Union *226
Biliary Tract Pathology—Palazzo *110
Bioflavonoids in Treatment of Common Cold—Sobel *625
Biopsy Manual (Hardy, Griffin and Rodriguez) br755
Blake, Albert J.† 639
Bleeding, Abnormal Uterine br360
Bleeding, Uterine—Ward *308
Blind, Special Syringe for ab323
Blindness, Pamphlets on 291
Blood Council 286
Blood Samples from Incompetent Patients e481
Blue Cross Rate Increase Hearing 682
Blue Shield Accepts the Challenge e592
Blue Shield and Geriatrics e364
Blue Shield Savings Bank e299
Blue Shield Service Benefits—Alfano *647
Bluestein, S. G., Paterson *602
Bone Tumors (L. Lichtenstein) br528
Book Reviews 37, 90, 149, 293, 359, 378, 526, 584, 640, 706, 754
Bowel, Cancer of—Goldberg *22
Bowel, Lesions of (R. J. Jackman) br360
Bowers, F. Clyde, Mendham e223, *484, *563
Bradford, Stella† 140
Brain Scanner—Rinzler, Miller and Jacobson *243
Brandman, Otto, Maplewood *24
Brittain, Elmore G.† 579
Brown, Roswell K., Buffalo, N. Y. *532
Buerger's Disease a Myth? ab510
Burlington County Medical Society 289, 355, 703, 751
Burt, Donald P., Morristown *251

1- 40—Jan.
41- 94—Feb.
95-152—March
153-222—April
223-296—May
297-362—June
363-480—July
481-528—Aug.
529-588—Sept.
589-644—Oct.
645-710—Nov.
711-768—Dec.

C

Caldwell, Anne E., Ph.D., Trenton *300
Camden County AAGP 749
Camden County Medical Society 147, 174, 211, 749
Cancer and the Atomic Age (C. A. Tavares) br149
Cancer Program in New Jersey—Part VII. Cancer Rehabilitation *337
Cancer, Treatment of (Edited by J. B. Field) br755
Cantelmo, A. L., East Orange *501
Carcinoid Syndrome—Pastras *160
Carcinoma (See organ affected)
Cardiovascular Disease Among Physicians—Reitman *673
Causation, Doctrine of e712
Cerebral Palsy, Meprobamate in—Drake *256
Cerebral Palsy, Trephine for ab495
Cerumenolysis with new Agent—Dirr *et al.* *504
Chaiken, Bernard H., Short Hills *232
Chest Physicians, American College of 522
Childbirth, Natural (H. Heardman) br756
Children, Pelvic Abscess in—Clemente *513
Chlorothiazide Medication—Tami and Shoshkes *652
Chocolate, Toxic Effects of ab23
Cholecystographic Medium, New—Bluestein *602
Cholesterol and Atherosclerosis (Prepared by H. I. Mattill) br360
Christmas Seals e646
Ciccone, Anthony C.† 701
Cigaret Filtration and Carcinogenesis ab338
Cigarettes and Cancer ab660
Cities are Healthier e41
Civil Defense-Disaster Control Committee Name Changed 568
Civil Defense Items 286, 583
Clemente, Celestino, Glen Ridge *513
Coagulation Defects in Pregnancy—Mc-Elroy *14
Cobalt, Radioactive ab680
Cohen, Burton M., Elizabeth *304
Cold, Common—Sobel *625
College "Drop-Outs" ab615
Colon, Diseases of (Edited by R. Turell) br755
Comando, Edward N., Newark *104
Committee Chairmen, List of (Advertising Page 3A)
Committees, List of (Advertising Page 4A, April and September JOURNALS)
Committees, Special 518
Communicable Diseases (Edited by J. B. Coates) br293
Community Mobility and Emotional Disorder—Gordon and Gordon *43
Compensation Fees 366
Congenital Heart Defects Booklet 159
Coniaris, John, Newark *605
Conn, Jacob H., Pikesville, Md. *491
Connolly, Henry A., Jr., Summit *264
Conroy, William C., Montclair *538
Constipation can be Fatal ab515
Contact Lenses 367, 570, 684
Convulsive Disorders of Children (Chao, Druckman and Kellaway) br526
Coriell, Lewis L., Camden *155
Coronary Artery Disease, Surgical Treatment of—Antonius *et al.* *605
Crandell, Archie, Greystone Park *553
Crawford, Georgina U.† 172
Crecca, Anthony D., Newark *605
Crime and Insanity (Edited by R. W. Nice) br38
Crippled Children, Booklets on 541, 748
Crooks, William J.† 172
Crumbling Cordon of Confidentiality e589
Cumberland County Medical Society 34, 174, 211, 289, 375, 751
Curing and Caring e153
Cysts, Mesenteric—Mattioli *49
Cytology, Expanding Frontier of—Miller *9

D

Dentists and MSP 568
Dermatology, Focal Infection in—Post and Jewell *620
Dermatomycoses, Treatment with Griseofulvin—Yontef *738
Dermatoses, Treatment with Perphenazine—Fanburg *332
Devine, John, J., V.M.D., Plainfield *671
Diabetes Award 199
Diabetes, How to Live With (Dolger and Seeman) br584
Diabetics, Warning to 537
Diagnosis, Aids to (G. E. Sutton) br527
Diarrhea, Approach to the Problem—Gilbert *735
Diarrhea, Clinical Aspects of—Fradkin *558
Diarrheas, Parasitic—Eisenberg *661
Dieffenbach, Richard H.† 140
Diet and Atherosclerosis—Edwards, Caldwell and Zealand *300
Difficult Diagnosis (H. J. Roberts) br293
Diphtheria is Still Here 112
Dirr, John P., Riverton *504
Disability and Social Security 571
Disability Evaluation (W. C. Smith) br754
Diuresis, Safer—Tami and Shoshkes *652
Doctor Business (R. Carter) br149
Doctor Remembers (E. H. Richardson) br527
Donnelly, Joseph P., Jersey City *656
Dr. Fixit e154
Drake, Miles E., Vineland *256
Drug Industry, Competition in e96
Drug, Prescribed, Labelling e645
Durrah, Fred F.† 747

E

Ecology of Human Disease (J. May) br754
Edwards, Margaret H., Trenton *300

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL

Egan, Thomas V., B.S., M.T., Trenton *113
Eisenberg, Samuel W., Philadelphia, Pa. *661
Elderly Patients, Health Insurance for 132
Electrocardiography (M. Bernreiter) br378
Electrophoretic Mobility—Rathmell, Egan and Mora *113
Emergency Hospital Units 286
Emergency Treatment and Management (T. Flint) br293
Emotional Disorder and Community Mobility—Gordon and Gordon *43
Engelberg, Recha, Ph.D., Newark *22
Engineers as Plastic Surgeons e363
Ephedrine in Allergies—Flothow *et al.* *733
Epilepsy Services for Children br359
Epileptic, Education of 702
Epileptics, Marriage of 143
Epstein, Harry B.† 31
Ergotism ab263
Essex County Medical Society 34, 88, 212
Essex County Pathologic and Anatomic Society—Berg *81
Eternal Search (R. Mathison) br294
Euphemisms in Advertising e154
Ever-Changing Practice of Medicine—Gardner *266
Experimental Medicine (C. Bernard) br91
Eye Examination Reports ab54

F

Failmezger, Theodore R.† 172
Fanburg, S. J., Newark *332
Fein, Bernard† 639
Feldman, Harold S., Livingston *339
Fetal Trauma Prevention—Donnelly *656
Fialk, Harry† 140
Finkler, Rita, Newark *555
Fischer, Edward J.† 373
Fischer, Harold M., Newark *97
Flothow, M. W., Jr., Morristown *733
Fluoroscopes, Shoe-Fitting ab236
Fluoroscopic Sign of Pulmonic Stenosis—Green *27
Foley, Joseph M. 635
Footprint Identification ab338
Fradkin, William Z., Brooklyn, N. Y. *558
Free Choice, Resolution on 365
Funeral Director: Friend in Need e483

G

Gait Disturbances in Children—Kummel *117
Galvanic Skin Response Audiometry—Goldstein and Rickenberg *507
Ganley, Arthur J.† 373
Gardner, Kenneth E., Bloomfield *3, *266
Gastrointestinal Disease, New Therapy—Landman *348
Gastrointestinal Roentgenography—Greenfield *128
Gieb, M. Eugenia, Letter from 525
General Practice in Britain e590
George, Melbourne E. W.† 747
Geriatric Patient (Edited by E. V. Cowdry) br294
Geriatrics and Blue Shield e364
Gilbert, Samuel M., Newark *735
Glaucoma Identification Card 284
Glickman, Stanley I., New York, N. Y. *677
Gloucester County Medical Society 34, 88, 174, 289, 357, 376, 582, 704
Goldberg, H. C., Plainfield *671
Goldberg, Samuel A., Newark *22
Goldblatt Kidney ab255
Golden Merit Award Ceremony—
1958 30
1959 686
Goldstein, Abraham† 378
Goldstein, Henry Z., Newark *507
Gordon, Katherine K., B.S., Englewood *43
Gordon, Richard E., Englewood *43
Gout and Idleness ab624
Gout, Notes on ab619
Gouveia, Sally, R. N., Boonton *667
Green, Henry, Newark *27
Greenfield, Herbert, Newark *128
Griseofulvin in Dermatomycoses—Yontef *738
Guinea Pig, Unintended e529
Gynecologic Aspects of Bleeding—Shipps *55
Gynecology, Diagnostic Aids br360

H

Hakim, Nurollah, Montclair *19
Hampton, George† 140
Harryman, William K.† 140
Hare, George T., Camden *487
Hasbrouck, Walter, Montclair *19
Hazards, Radiologic 353
Headache Caused by Masticatory Contractions—Monica *335
Health Statistics br293
Hearing: A Handbook for Laymen (N. Canfield) br586
Hearing, Microsurgery of—Sophocles *321
Heart Attacks, What we Know About (J. W. Gofman) br37
Heart Disease Among Physicians—Reitman *673
Heart Disease and Work ab242
Heart Disease, Compensability of ab336
Hematologic Diseases, Joint Changes in—Sperling *593
Hemoglobin Mobility—Rathmell, Egan and Mora *112
Hemorrhage due to Paracentesis—Hakim, Hasbrouck and Spiro *19
Hemorrhage, Gastric ab744

1- 40—Jan.
41- 94—Feb.
95-152—March
153-222—April
223-296—May
297-362—June
363-480—July
481-528—Aug.
529-588—Sept.
589-644—Oct.
645-710—Nov.
711-768—Dec.

Hemorrhage in Gynecology—Shipps *55
Hernia, Inguinal—Brown *532
Hessert, Edmund C.† 579
Heyman, Arthur, Newark *62
Higi, Joseph E., East Orange *545
History of Science Award 356
Hosp, Paul† 140
Hospital, American e299
Hospital Staphylococcal Infections—Coriell *155
Hospitalization Survey 282
Hudson County Medical Society 35, 147, 290, 582, 704, 752
Hudson, Phoebe, Westwood *496
Hypertension Treated by Rauwolfia—Cohen *304
Hypertension, Urologic Aspects of—Murphy *76
Hypertensive Disease (S. W. Hoobler) br707
Hyperthyroidism Treatment by Radioactive Iodine—Levinson *120
Hypnosis, Medical, Abuse of—Conn *491

I

Ice Cream, Low Calorie ab562
Imagery of Medical Words e530
Incompetent Patients and Blood Samples e481
Industrial Medicine, Training in 749
Infarction, Omental—Sakson *511
Infertility, Emotional Factors in—Comando *104
Insomnia and Dreams (L. Gilman) br149
Institutional Physicians, Liability Insurance for 366, 370
Insulin Treatment in Psychiatry (Edited by Rinkel and Himwich) br708
Inter-professional Medical-Legal Code 134, 568, 681
Intestines, Cancer of ab23
Intoxication, Acute, Treatment of (Deichman and Gerarde) br640
Intravenous Therapy by Nurses 169, 681
Iron Metabolism—Nussbaum *237
Irradiation and Genetics ab613

J

Jacobs, Alan L., Union *232
Jacobson, Lillian E., M. A., Newark *243
Jaundice Precipitated by Prochlorperazine—Crandell and Ma *553
Jet Travel, Hazards of ab601
Jewell, William, Ridgewood *620
Johnson Award 159
Joint Changes in Malignant and Hematologic Diseases—Sperling *593
Judicial Councilors, List of (Advertising page 3A each issue of THE JOURNAL)

K

Kain, Thomas M., Jr., Camden *99, *487
Kallos, Andrew, Kearny *327
Kaplan, S., Plainfield *671
Karel, Jack R., C. D. Award 313
Kavanaugh, Daniel E., Newark *713
Keeney, Cadwell B.† 373
Kelly, Leo† 141
Kennedy, A. Andrew† 579
Kieswetter, Dayton T., East Orange *316
Kindler, J., Plainfield *671
Kinley, John W.† 285
Kolisch, Paul de R., Phillipsburg *741
Kuhn, Robert A., Morristown *68
Kummel, Bertram M., Morristown *117

L

Label, Following Directions on ab718
Labelling the Prescribed Drug e645
Laboratory, Solicitation by 132
Landman, Milton E., Bloomfield *348
Lawyers, Medical Course for e531, 580
Lead or Be Led—Bowers *485
Leevy, Carroll M., Jersey City *163
Leggett, Lindley H.† 579
Legislation, Report on 368
Lesions of Lower Bowel (R. J. Jackman) br360
Leukemia, Joint Changes in—Sperling *593
Leukemia Study 284
Levinson, Louis J., Newark *120
Levitas, Irving M., Westwood *496
Levitzky, Edward, Newark *62
Levonol® in Appetite Control—Feldman *339
Liability and Progress e95
Liability Insurance for Institutional Physicians 366, 370
Life Insurance for Members 138
Life Insurance Quota 521
Lin, Hazel 287
Liothyronine in Thyroid Therapy—Finkler *555
Liver Disease, X-Ray Studies—Perlberg, Perlberg and Leevy *163
Loan Fund for Interns and Residents 672
Long Term Illness (Edited by M. G. Wohl) br706
Love, Skill and Mystery (T. Bovet) br92
Lung Tumors (B. M. Fried) br150
Lymphoma Study 284

M

Ma, John Y., Greystone Park *553
Mackowsky, Edwin† 285
Madribon, Study of—Brandman, Oyer and Engelberg *24

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL

Maggio, George A. 170
Magson, Albert E.† 172
Malignant Carcinoid 634
Marginalia of Medicine 33, 86, 525
Marin, Robert B., Montclair e225, *629
Maronpot, R. C., Morristown *733
Mason, Stuart A., Ridgewood *542
Massarelli, Lucian G., Newark *605
Masticatory Muscles Causing Headache—Monica *335
Mattioli, Elmer N., Vineland *49
Maturity, Emotional (D. Abrahamsen) br38
Maxillo-Facial Injuries—Conroy *538
McElroy, Robert C., Philadelphia, Pa. *14
McGuinn, William B.† 747
McKinney, Thomas S.† 373
M.D. License Plates 636
Medical Society of New Jersey, Committee Functions of 574
Medical Society of New Jersey, Organizational Structure 572
Medical-Surgical Plan Discussion 688
Medical Teaching to Lawyers e531
Medicare Changes 683
Medicine, Textbook of (Edited by Cecil and Loeb br756
Medicine's Shield of Security e1
Medico-Legal Code 134
Membership Directory Supplementary List No. 1 637
Mental Hospital Programming 283
Mental Retardation Film 581
Meprobamate in Cerebral Palsy—Drake *256
Mercer County Medical Society 89, 147, 212, 290, 357, 376, 704, 752
Merck Memorial Fund e646, 672
Mesenteric Cysts—Mattioli *49
Methyl Salicylate Poisoning—Burt *251
Meyer, John, Montclair *504
Microsurgery of Hearing—Sophocles *321
Middlesex County Medical Society . . . 35, 89, 148, 174, 290, 357, 376, 524, 752
Miller, Howard B., Fair Lawn *9
Miller, Wade N., Newark *243
Monica, Woodrow S., D.M.D., Orange *335
Monmouth County Medical Society . . . 175, 215, 582, 705, 753
Mora, Jorge, Trenton *113
Morris County Medical Society 216
Mouth to Mouth Respiration ab670
Murphy, John J., Philadelphia, Pa. *76
Musetto, C. A., Boonton *667
Muttart, George W.† 373
Myocardial Infarction and Arrhythmias—Rosenberg 258

N

National Tuberculosis Association Abstracts 39, 93, 151, 221, 295, 361, 587, 643, 709, 767
Navy Surgeon (H. L. Pugh) br642
Nesbitt, Robert E. L., Jr., Albany, N. Y. . . . *719
Neuroanatomy (Ranson and Clark) . . . br707
Neurosurgery in World War II (Edited by Coates *et al.*) br640
New Jersey Allergy Society 377
New Jersey Dermatological Society 377
New Jersey Orthopaedic Society 705, 754
New Jersey Proctologic Society 378
Newell, William Augustus—Rogers *278
Niner, Harold, Passaic *504
NND, 1959 . . . . . br707
Now or Never (Blanton and Gordon) br756
Nuclear Medicine, Journal of 749
Nurses and Intravenous Therapy 169, 681
Nussbaum, Murray, Jersey City *237

O

OASDI Reports Not Confidential 636
Obituaries 31, 140, 172, 285, 373, 526, 579, 639, 701, 747
Obstetrics and Gynecology (J. R. Willson *et al.*) br584
Obstetrics-Gynecology Diplomates 371
Occupational Bronchial Asthma—Weiner . . *616
O'Connell, William M.† 141
O'Crowley, Clarence R.† 285
Officers, List of (Advertising Page 3A each issue of THE JOURNAL)
Offices to be Filled by Election 137
O'Kane, M. J., New Brunswick *504
Omental Infarction—Sakson *511
Only Baby (S. Cholst) br37
Osler, Writings of br584
Osteopaths, Association with 132, 569
Otolaryngology, Fundamentals of (L. B. Boies) br642
Oyer, Calvin, Newark *24, 159

P

Palazzo, William L., Teaneck *110
Paracentesis Causing Hemorrhage—Hakim, Hasbrouck and Spiro *19
Parasitic Diarrheas—Eisenberg *661
Parry, Allen A., Madison *725
Passaic County Medical Society 36, 89, 148, 175, 217, 291, 358, 376, 705, 753
Pastras, Thomas, Collingswood *160
Paternity Referee, Function of—Rathmell . . *730
Patient's Team—Gardner *3
Pediatrics Textbook (Edited by W. E. Nelson) br708
Penicillin and Salk Vaccine ab250
Penis, Cancer of ab724
Penis, Fracture of—Saxe *614

1- 40—Jan.
41- 94—Feb.
95-152—March
153-222—April
223-296—May
297-362—June
363-480—July
481-528—Aug.
529-588—Sept.
589-644—Oct.
645-710—Nov.
711-768—Dec.

Peritendinitis and Tendinitis—Kavanaugh *713
Perlberg, Harry J., Jr., Jersey City *163
Perlberg, Harry J., Sr., Jersey City *163
Perphenazine in Dermatoses—Fanburg *332
Perphenazine in Gastrointestinal Disease—Landman *348
Pharmaceuticals of 1958 e224
Pharmacodynamics, Experimental (Koppanyi and Karczmar) br91
Phosphatase Levels—Cantelmo *501
Phosphorus, Radioactive ab495
Physic to the Dogs e2
Physician Looks at Psychiatry (J. M. May) br150
Physicians, Heart Disease Among—Reitman *673
Physiotherapy and Rehabilitation—Bowers *563
Pierson, William, Letter from—Rogers *745
Plasma Proteins (P. G. Weil) br586
Pneumonia, Staphylococcus—Kain, Waugh and Hare *487
Poison Control Centers 144
Poisoning (W. F. van Oettingen) br359
Poliomyelitis, Vaccination for 133
Pollack, Roy, Englewood *550
Positron Brain Scanner—Rinzler, Miller and Jacobson *243
Post, Charles F., Ridgewood *620
Postmaturity ab263
Pregnancy, Coagulation Defects in—McElroy *14
Pregnancy, Myths of ab757
Prematurity, Prevention of—Nesbitt *719
Premedication for Vomiting Control—Musetto, Ward and Gouveia *667
Prenatal Specimens 287
Preservation of Youth (M. ben Maimon) br92
Prevention of Fetal Trauma—Donnelly *656
Prochlorperazine in Alcoholism—Rogers *247
Promotion Masquerading as Science e297
Prostate, Resection of—Glickman *677
Pruritus—Higi *545
Psychiatry, History of (E. H. Ackerknecht) br755
Psychiatry,Modern Clinical (Noyes and Kolb) br91
Psychic Phenomena, World of (F. S. Edsall) br37
Psychoanalysis, Technic of (L. J. Saul) br585
Psychoanalyst, Skeptical (K. M. Colby) br640
Psychogenic Factors in Infertility—Comando *104
Psychology of Medical Practice (M. H. Hollender) br378
Psychotherapeutic Drugs (A. L. Welsh) br527
Pulmonary Veins, Anomalous Return of—Sarewitz and Ward *611
Puppeteers—Detail Men 523

R

Radiation Registry 633
Radioactive Iodine in Hyperthyroidism—Levinson *120
Radiographic Anatomy Atlas (Meschan and Farrer-Meschan) br707
Radiologic Hazards 353
Radiologic Studies of Liver Disease—Perlberg, Perlberg and Leevy *163
Radiology, Protection in (Edited by B. P. Sonnenblick) br586
Rathmell, Thomas K., Trenton *113, *314, *730
Rauwolfia in Hypertension—Cohen *304
Rehabilitation and Physiotherapy—Bowers *563
Rehabilitation in Cancer *337
Rehabilitation Medicine (H. W. Rusk) br38
Reitman, Norman, New Brunswick *673
Resection, Endoscopic, of Prostate—Glickman *677
Respiration, Artificial ab670
Retirement Plan for Physicians 169
Reversicon (J. E. Schmidt) br360
Rheumatic Fever Prevention—Kain *99
Richardson, Edward H., M.D. br527
Rickenberg, Herbert E., M.A., Newark *507
Ridley, James B., Englewood *566
Riley, Philetus H.† 141
Rinzler, Elliot, Newark *243
Rizzolo, Edward M.† 701
Roentgenography, Postoperative—Greenfield *128
Rogers, Fred B., Trenton *278, *630, *745
Rogers, George A., Camden *247
Rogers, Lawrence H.† 747
Rosamilia, Ralph, Newark *97
Rosenberg, Alvin A., Morristown *258
Rowohlt, Mrs. George O., Auxiliary President 292
Ruoff, Andrew† 141
Rushmore, R. J., Morristown *733

S

Sakson, John A., Camden *511
Salem County Medical Society 36, 90, 148, 175, 218, 291, 358, 377, 705, 753
Salt Substitutes ab54
Sarewitz, Albert B., South Orange *611
Saxe, Theodore L., Jersey City *614
School Health Programs—Hudson and Levitas *496
Sedimentation Rate (F. Wright) br294
Serum Phosphatase Levels—Cantelmo *501
Servant of Medicine e225
Seton Hall Neurology Director 635
Sexual Surrender, The Power of (M. N. Robinson) br641
Seymour, George A.† 31
Sherman, A. Russell, Newark *60
Sherman, Elbert S.† 639
Sherman, Samuel H., Newark *324
Shipps, Hammell P., Camden *55
Shoshkes, Milton, Newark *652
Side Effects, Reporting of e712
Simmons, Albert V.† 141
Sirken, Charles† 579
Sjogren's Syndrome 578
Skeptical Psychoanalyst (K. M. Colby) br640

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL.

Skin Disease and Animal Contacts—Goldberg *et al.* *671
Skin Diving may be Unhealthy ab624
Smoking and Birth Rates ab21
Sobel, I. J., Passaic *625
Social Security Determination 350
Social Security Reports for Patients 137
Social Security Statistics ab8
Society for the Relief of Widows and Orphans 176, 378
Sophocles, A. M., Trenton *321
Sperling, Irving L., Newark *593
Spinner, Samuel† 141
Spiro, Robert K., Montclair *19
St. Michael's Hospital, New Pediatric Director 170
Staphylococcal Infections in Nursery—Coriell *155
Staphylococcus Pneumonia—Kain, Waugh and Hare *487
State Hospital Areas 85
Statistics (F. Croxton) br708
Statistics (A. Franzblau) br708
Statistics, Health br293
Stenosis, Pulmonic, Fluoroscopic Signs of—Green *27
Sterility, Emotional Factors in—Comando *104
Steroids in Childhood Tuberculosis—Heyman and Levitzky *62
Stites, Hezekiah—Rogers *630
Stomach, Bleeding of ab744
Stomach Rupture of Newborn—Kolisch *741
Story Behind the Word (H. Wain) br527
Stouter, Francis L.† 526
Strazza, John A., Jr., Bloomfield *124
Stroke, Management of—Kuhn *68
Stroke, Surgery of ab347
Stuttering Booklet Available 287
Sulfonamide, Long-Acting—Brandman, Oyer, and Engelberg *24
Surgery, Atlas of Technics in (J. L. Madden) br585
Surgery, Vascular (G. de Takats) br528
Surgical Pathology (Ackerman and Butcher) br640
Survival After Potentially Fatal Complications—Fischer and Rosamilia *97

T

Tami, Mario, Newark *652
Tansey, W. Austin, Short Hills *232, *343
Tarbell, Harold A., Retirement of 371
Television Medicine e225
Tendinitis and Peritendinitis—Kavanaugh *713
Tensions, Mastery of (Stevenson and Milt) br756
Terminology, Medical, Simplified (L. L. Perkel) br585
Tetanus—Chaiken, Tansey and Jacobs *232
Throat, Lump in ab746
Throw Physic to the Dogs e2
Thyroid Replacement Therapy—Finkler *555
Thyroid Treatment of Thinness—Kieswetter *316
Tinea Capitis—Kallos *327
"To Repeal All Medical Laws . . ."—Rogers *745
Toenail, Ingrown ab331
Tomahawk Wound, Modern ab13
Transactions 379
Translation Service 581
Trauma, Fetal, Prevention of—Donnelly *656
Triarsi, Aonthony J.† 747
Trifluor Perazine (Edited by H. Brill) br642
Trustees, Board of, Meetings—
November 16, 1958 131
January 18, 1959 131
February 15, 1959 282
April 12, 1959 365
April 24, 1959 366
April 28, 1959 366
May 17, 1959 516
June 28, 1959 568
September 20, 1959 681
Truth, Risk of Telling e591
Tuberculosis and Influenza ab737
Tuberculosis in Childhood—Heyman and Levitzky *62
Tuberculosis in Private Practice—Biber *226
Tumors of Bone (L. Lichtenstein) br528
Twins, Handbook for Mothers br359
Twins in Paternity Disputes—Rathmell *730
Tyrrell, George W.† 579

U

Ulcer, Peptic, in the Aged—Mason *542
Underweight, Thyroid Treatment—Kieswetter *316
Union County Medical Society 36, 176, 218
Urinary Diversion—Whittle *108
Urologic Aspects of Hypertension—Murphy *76
Urology in General Practice (Hamm and Weinberg br91
Uterine Bleeding—Ward *308

V

Vacation in Mountains ab734
Van Dyke, Joseph S.† 639
Vascular Surgery (G. de Takats) br528
Ventricular Standstill—Tansey and Wagner *343
Veterans, Care of, by Private M.D.—Sherman *324
Visual Efficiency, Appraisal of Loss—Sherman *60
Vomiting, Postoperative, Control of—Musetto, Ward and Gouveia *667

W

Wagner, Richard, Summit *343
Ward, A. J., Boonton *667

1- 40—Jan.
41- 94—Feb.
95-152—March
153-222—April
223-296—May
297-362—June
363-480—July
481-528—Aug.
529-588—Sept.
589-644—Oct.
645-710—Nov.
711-768—Dec.

Ward, Elisabeth B., Newark *308
Ward, R. Wendell, South Orange *611
Warren County Medical Society 220
Water and Electrolyte Metabolism br90
Watts, Wilbur† 639
Waugh, Bascom S., Camden *487
Weiner, Aaron, Fair Lawn *616
Welfare Committee Meeting of March 8, 1959 367
White, Rostin† 701
Whittle, George T., Asbury Park *108
Williams, William Carlos 85
Winslow, John H.† 31
Wintergreen Poisoning—Burt *251
Woman's Auxiliary President 292
Woman's Auxiliary Program 132
Women, Diseases of (F. W. Roques *et al.*) br706
Work for Cardiacs ab242

X

X-ray Hazards ab732
X-ray Stinginess—Rathmell *314
X-ray Technology—Patient Care (Vennes and Watson) br528

Y

Yontef, Reuben, Bayonne *738
Youthful Offenders at Highfields (H. A. Weeks) br359

Z

Zealand, Margaret, M.S., Trenton *300
Zvaifler, Nathan† 701

---

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

DECEMBER, 1959 ● VOL. XXXII, No. 10

THE FUTURE OF TUBERCULOSIS

In a current series of medical progress reports the author takes a long look at the present situation in tuberculosis therapy and control. His summary reprinted here is also a forecast of the future course of this ancient disease in our society.

A look at the future may perhaps best summarize the important aspects of tuberculosis and its treatment, giving a slant to the trends of tuberculosis control and eradication.

There is reason to believe that the recent precipitous downward trend in the mortality of tuberculosis will slacken in the years ahead and that the incidence of new cases will continue to be significant as long as the large community reservoir of tuberculosis of uncertain activity is fed from so many sources.

The eradication of tuberculosis is no longer a local or a national problem, but a world-wide concept needing cooperation and support on a community as well as on an international basis.

Tuberculosis, having become an affliction of older people, should witness a fall in incidence as the members of the older generation pass on with their disease. The present younger generation, with a low infection rate, will in time take its place with less open disease more adequately treated and probably with good chemoprophylactic control of their infection. But this is a slow process, in which Darwinian survival and elimination will still play their part in treatment and prevention.

Tuberculosis has always been a family disease, most prevalent and devastating when families were commonly larger than they are today. But whatever occurs in the family size, home care of tuberculosis, unless carried out with meticulous regard for its infectiousness, may well influence the epidemiology of tuberculosis unfavorably in the future. However home care is managed, the family physician—whether he is internist or general practitioner—will continue in a key position in the use or abuse of the measures of control.

TUBERCULIN TEST

The tuberculin test will become increasingly important as the infection rate of tuberculosis falls. When the older age groups contain an increasing number of nonreactors, the tuberculin test will gain increasing usefulness in both case finding and the differential diagnosis of pulmonary lesions. The continuing record of the individual tuberculin reactor will be followed from the date of conversion to a positive tuberculin test. Depending on the age of the child or adult, this record of tuberculin-conversion—a sort of tuberculin case registry—will determine the need of treating the primary infection before the signs of overt disease appear.

Chemotherapy of the tuberculin converter to positive will become more widely used in infants under three years and in adolescents over fourteen years of age.

Isoniazid will be applied more widely as a preventive in the groups past forty years of age with known old lesions of uncertain and potential activity. Chemotherapy will be used for longer periods, perhaps indefinitely in those who have completed standard initial regimens but who end with open cavities unsuitable for surgery or with characteristics of instability in their lesion.

Better drugs may be found in the future. But isoniazid will undoubtedly be found efficient in controlling bacilli that break loose from dense

THEODORE L. BADGER, M.D., *The New England Journal of Medicine, July 16, 1959.*

cellular structures or from the heart of caseous lesions.

Concepts of adequate versus inadequate chemotherapy will without question greatly alter the future control of tuberculosis.

BCG will in the future have decreasing usefulness in communities and nations that have become sophisticated in modern chemotherapy and the use of isoniazid in the prevention of the complications of primary infections.

FUTURE OF SANATORIUMS

Sanatoriums, though fewer in number, will continue for the care of the long-term cases of tuberculosis. It seems inevitable and proper that initial care of acute tuberculosis will move more and more into the general hospitals.

Tomorrow, the tuberculosis sanatoriums may take on community leadership in the treatment and control of tuberculosis. They could encourage friendly relations with the family doctor and the thoracic physician or surgeon who will care for their patients after discharge. They could gain the confidence of patient and referring physician by a close understanding that comes only with intellectual "give and take" with a diffusion of knowledge between those inside and outside the sanatorium, both of whom are interested in tuberculosis and guard the welfare of their patients. The future holds a neat opportunity for the sanatoriums that work closely and intelligently with the family physician, and their continued survival may depend on such cooperation. In these days of home care of tuberculosis the opportunities of the sanatorium for undergraduate and postgraduate community education in tuberculosis could be very great and this deserves serious thought.

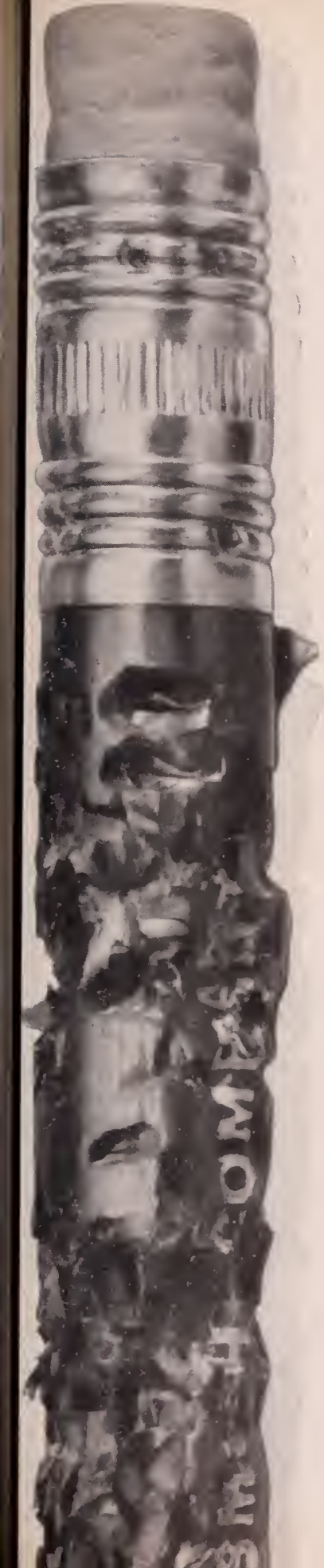
The x-ray will continue to be the most important tool in chest diagnosis in spite of radiation hysterias. Manufacturers will produce safer x-ray machines and better protective devices but only if radiologists can be persuaded to use them and patients can be urged to request them.

General-hospital admission x-ray programs for those over thirty years of age will be given wider recognition for their usefulness in case findings for both tuberculosis and cancer of the lungs. In the old-age groups that populate general hospitals, there is interest not only in finding the new and unknown cases of tuberculosis but also in re-locating the known recalcitrant and the unknown relapses found by chance.

Education in tuberculosis will be a continuing job in the future among members of the medical profession and the laity. Research will require larger funds as the task of eradication becomes more difficult. The time has passed for being impressed with either the decreasing mortality or the specific number of reportable cases of tuberculosis. Rather, one should gear all planning toward the many more millions of people who are infected with tubercle bacillus and toward those who are the potentially active cases of tuberculosis of the future. The importance of following known, treated tuberculous persons for the prevention and detection of relapse will be a far tougher job in the future than the detection of new active cases of tuberculosis.

The goal of eradication of tuberculosis, ephemeral as it may be, will not even appear on the horizon until the perspective of both national and world-wide control is understood by every community, no matter how small. There are years of intensive and imaginative work ahead. There is probably no short cut to the ultimate victory. Tuberculosis is still embedded in people in every corner of the world, and world-wide cooperation and expenditure of both energy and money will be needed for many years.

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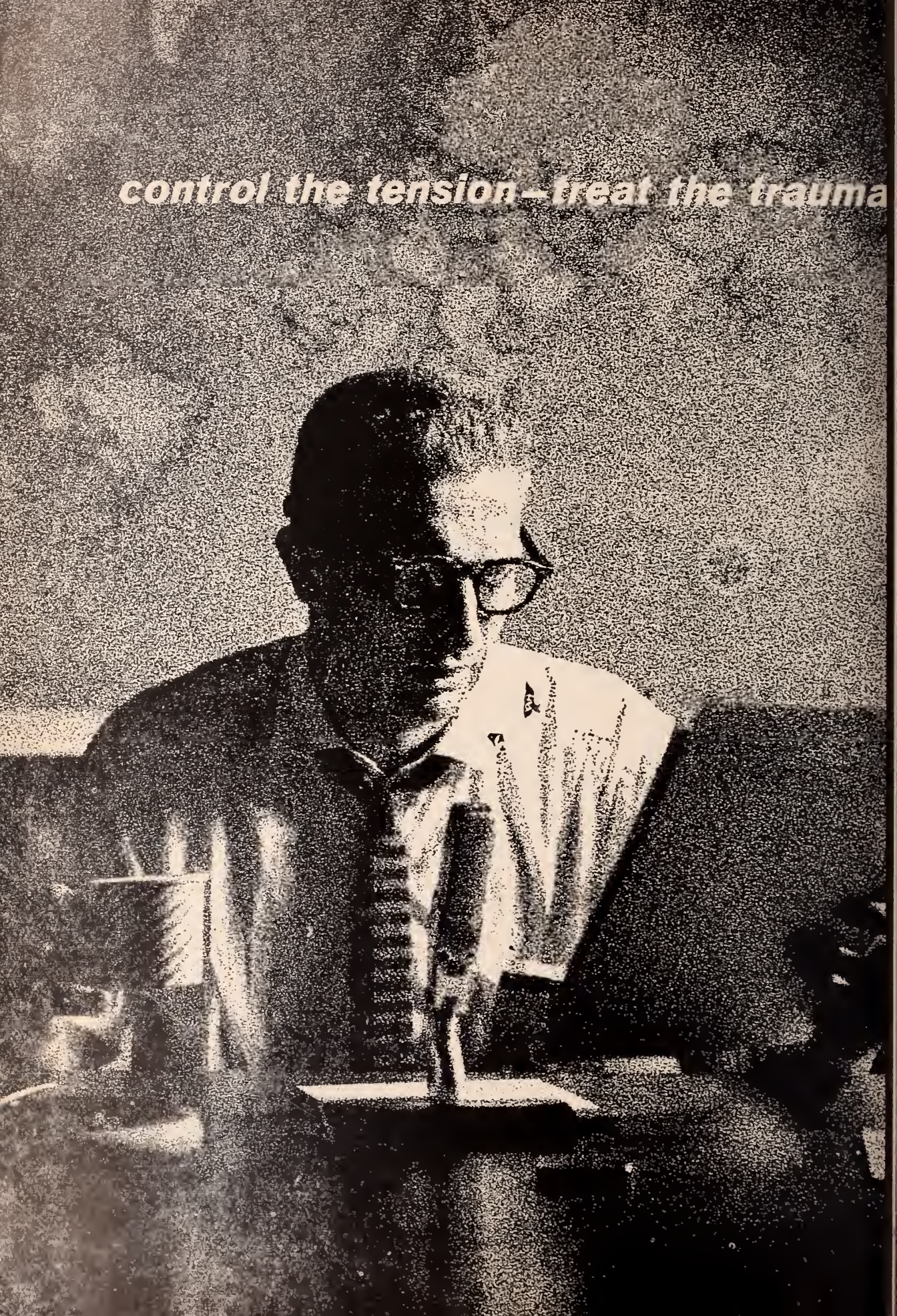
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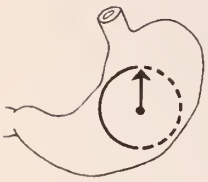
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